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ELDERLY NUTRITION: POLICY ISSUES FOR THE 102ND CONGRESS

JOINT LEGISLATIVE WORKSHOP

BEFORE THE

SPECIAL COMMITTEE ON AGING

AND THE

COMMITTEE ON AGRICULTURE, NUTRITION, AND FORESTRY
UNITED STATES SENATE

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PREFACE

ELDERLY NUTRITION: POLICY ISSUES FOR THE 102ND CONGRESS

As is the case with all Americans, nutritional well-being is an integral part of senior citizens' overall health, independence, and quality of life. Incredibly, however, millions of our elderly citizens suffer from inadequate nutrition.

One out of every two Americans is affected by poor nutritional status and/or nutrition-related health problems. The reasons for this unacceptable situation vary, but they include a reduction in social contact, poor eating habits, economic hardship, and frailty.

In an effort to focus greater attention on the nutritional needs of older Americans, the Special Committee on Aging and the Committee on Agriculture, Nutrition, and Forestry sponsored "Elderly Nutrition: Policy Issues for the 102nd Congress." The purpose of this roundtable discussion was to emphasize the vital role nutrition plays in assuring a healthy older population and to develop practical options for the Congress to consider during this year's reauthorization of the Older Americans Act (OAA).

Federal and State legislative initiatives have created a number of programs and services to assist older persons living independent or semi-independent lives. For the past 25 years, the OAA has served as the primary vehicle for the organization and delivery of a variety of social and nutrition programs. These programs serve to enhance the overall quality of life for older persons.

Specifically, Title III of the OAA authorizes supportive and nutrition services, including the congregate and home-delivered meal programs. The nutrition initiatives are the most visible programs under the Act. Of the $1.2 billion appropriated for the OAA in FY 1990, nutrition services represented 46 percent of the total appropriations. Moreover, of the $901.8 million appropriated to fund Title III programs, 66 percent was allocated specifically to nutrition services.

Currently, service providers are required to meet a minimum of one-third of the recommended daily allowance (RDA) per meal. Because this is the only nutrition standard required under the OAA, aging advocacy groups and organizations are concerned about the quality of the meals being served to participants, as well as how effective these meals are in improving nutritional status.

As Congress moves to reauthorize the Older Americans Act, an excellent opportunity is presented to review current Title III nutrition programs and to enhance these services by incorporating practical policy recommendations. During this year's reauthorization, aging advocacy organizations have identified the development of a minimum set of nutrition standards as one of several factors imperative to improving current nutrition services under the Older Americans Act. In an unprecedented move, the American Dietetic

Association (ADA), the National Association of Meal Programs (NAMP), and the National Association of Nutrition and Aging Services Programs (NANASP) joined together to develop a set of minimum standards for the OAA meal programs.

The recommended standards served as the focal point for the detailed roundtable discussion concerning nutrition issues. Throughout the course of the discussion, a wide array of issues were touched upon including provisions for quality control; nutrition education; in-service training (to personnel); employment of registered dieticians at the Federal, State, and local level; transportation; and sanitation issues.

It is my hope that the recommended nutrition standards will be explored further to determine the feasibility of incorporating them into the Older Americans Act. These standards and the rationale for them is documented in the pages that follow. I hope this print will be a valuable resource during this year's reauthorization of the Older Americans Act.

In closing, I want to express my sincere appreciation to a number of individuals and organizations who contributed their valuable time and effort in making this program a success. I extend a very special thanks to the following organizations: the American Dietetic Association, the National Association of Meal Programs, the National Association of Nutrition and Aging Services Program, the Nutrition Screening Initiative, local and State area agencies on aging, the Department of Agriculture, the Administration on Aging, and the Ohio Department of Aging. Additionally, a warm and hearty thanks is given to Carol O'Shaughnessy of the Congressional Research Service for serving as our moderator, and an invaluable OAA resource. I also extend my appreciation to the following staff members who were instrumental in organizing this event: Ed Barron of the Agriculture Committee, and Andrea Boldon, Heather Burneson, and Anna Kindermann of the Aging Committee.

We can no longer tolerate having one-half of the Nation's elderly suffer from poor nutrition. It is my sincere belief that the contents of this publication will make a modest contribution toward improving this unacceptable situation.

David Pryor,
Chairman, Special Committee on Aging.

STATEMENT OF SENATOR PATRICK LEAHY ON THE JOINT LEGISLATIVE WORKSHOP: "ELDERLY NUTRITION: POLICY ISSUES FOR THE 102ND CONGRESS"

On behalf of the Agriculture, Nutrition, and Forestry Committee, I am pleased to sponsor this legislative workshop on elderly nutrition with the Special Committee on Aging. It has been well documented that poverty is a major cause of inadequate nutrition. The direct relationship between age and other influences on diet, however, is less clear. This workshop serves as an important educational forum on age and nutrition, and furthers the search for a solution to elderly malnutrition.

I am concerned that the low-income elderly need more focused attention. The low-income elderly with limited resources are often hit very hard by financial crises, and consequently their nutritional health suffers. The vulnerability of the elderly to the effects of malnutrition is a significant factor in the rising health care costs in this country.

Although low-income elderly participate in a variety of Federal nutrition programs, too many do not take advantage of these resources. The 1990 "Elderly Programs Study," issued by the U.S. Department of Agriculture, concludes that the major USDA food assistance programs are reaching only about half of the eligible low-income elderly.

This year, the Congress will be looking carefully at these problems when it reauthorizes the Older Americans Act. The Agriculture Committee has taken important steps to reach more of the elderly through food assistance programs, and we continue to seek ways to address the special nutritional problems of the low-income elderly.

I wish to thank Senator Pryor for his leadership on this issue, and I look forward to working with him and the Special Committee on Aging as we follow up on the issues raised by this workshop.

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ELDERLY NUTRITION: POLICY ISSUES FOR THE 102D CONGRESS

THURSDAY, FEBRUARY 15, 1991

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met, pursuant to notice, in the Dirksen Office Building.

Staff present: Portia Porter Mittelman, staff director; Heather Burneson, professional staff; Anna Kindermann, professional staff; Andrea Boldon, intern; John Monahan, Senator Pryor's personal staff; and Edward Barron, deputy chief counsel, Committee on Agriculture, Nutrition, and Forestry.

OPENING STATEMENT OF PORTIA PORTER MITTELMAN, STAFF DIRECTOR OF THE SENATE SPECIAL COMMITTEE ON AGING

Mrs. **MITTELMAN**. Good morning, everyone.

My name is Portia Mittelman, and I'm the Staff Director for the Senate Special Committee on Aging. I want to thank you very much for joining us this morning.

Before we begin, I would like to introduce a few of the staff members from the majority staff of the Aging Committee.

First of all, Anna Kindermann, who is our expert on the Older Americans Act. Seated next to her is John Monahan, who has provided a great deal of technical legal assistance to the Committee concerning the Older Americans Act.

I would also like to introduce a young woman who is interning with our office who has really done a great deal to help us put the workshop together, Andrea Boldon. Andrea is a student at James Madison University, and she truly has done an exceptional job.

And finally, Heather Burneson, who has truly been the driving force behind this legislative workshop. I am now going to turn it over to Heather.

STATEMENT OF HEATHER BURNESON, PROFESSIONAL STAFF, SPECIAL COMMITTEE ON AGING

Ms. **BURNESON**. Thank you, Portia.

I want to welcome all of you here today. I am going to be brief so that we can get right into this morning's discussion on elderly nutrition.

The National Association of Meal Programs (NAMP), the National Association of Nutrition and Aging Services Programs (NANASP) and the American Dietetic Association (ADA) have worked together to develop a set of standards to serve as a basic framework for us to start our discussion today.[1] As you know, the purpose of this workshop is to develop recommendations for the nutrition program under the Older Americans Act for reauthorization.

It is the hope of the Committee that this document will generate a great deal of discussion, that today, we will add to it, and hear both the pros and cons from you. This is the reason we have brought you here today, so please speak up.

There are microphones at each end of the room; if you have any comments, please stand at those microphones because we are going to be taping—a court reporter will be providing a transcript of this discussion.

I will now turn this over to our moderator, Carol O'Shaughnessy, who is with the Congressional Research Service (CRS). Carol is the CRS expert on the Older Americans Act.

STATEMENT OF CAROL O'SHAUGHNESSY, CONGRESSIONAL RESEARCH SERVICE

Ms. O'Shaughnessy. I'd like to welcome you to this roundtable discussion, sponsored by the Senate Special Committee on Aging and the Senate Agriculture Committee today. I am Carol O'Shaughnessy of the Congressional Research Service. CRS is a research arm in support of the committees and Congressional offices.

The workshop today is divided into two parts. This morning the discussion will focus on an overview of the nutrition programs and on suggestions for reauthorization that have been developed by the various nutrition groups you have before you. We will also hear some suggestions from ADA, NANASP and NAMP about suggested minimum standards that they have developed as a group.

In this afternoon's session, you will hear from the staff of the Senate Agriculture Committee and some remarks on the need for nutrition services from the State agencies on aging.

The committees have, as you can see, chosen the workshop format for today's session. The idea is to spark a dialogue among the panelists and the audience. The committees really want to hear from you in terms of issues that you see as being important for the future of the nutrition program. So we are hoping for a good discussion here.

As Heather said, the meeting is being recorded and your remarks will be included in the committee print. The committees have also asked that if persons have other comments outside of the meeting today in terms of written testimony that you would like to submit, those remarks or testimony can be submitted at a later time and they will also be included in the print that the committee will be preparing.

I just want quickly to go over the schedule for today. We will have this morning session, and we need to break promptly at 11:45 for a nutrition reason. The cafeteria closes at 12 o'clock to all but congressional staff, so we will ask you to go downstairs, grab a sandwich, come back up here, bring your sandwich here, and we will continue the discussion for the morning presentation until about 12:45, at which time we will have the second group of panelists.

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[1] See appendix, p. 59.

Before introducing the panelists, I just want to make a few introductory remarks to put the nutrition program into some sort of perspective.

While it is one of the many service programs authorized under the Older Americans Act, it is probably the most visible and has the longest history within the Act. Next year, as you all know, the program will be celebrating its 20th anniversary as a separately authorized program within the Act itself. The program first evolved from demonstration programs that were supported by the Administration on Aging in the late 1960's and received authorization in the 1972 amendments to the Act.

Congress envisioned the program as an important vehicle for fostering social interaction among participants by delivering social services to them, as well as nutritional services. In 1978, a separate authorization was added for the home-delivered meals program. As you know, there is a third component, administered by USDA, the commodity or cash in lieu of commodities program, which is a very important component of the nutrition program.

I just want to make a few points about current funding. Not only is the nutrition program the most visible under the Older Americans Act, it also receives the largest portion of Older Americans Act funding. In 1991, the total funding under the Act is $1.3 billion, of which the nutrition program represents 45 percent. That's about $600 million for nutrition under the total Older Americans Act.

Within the Title III program itself, which authorizes many other services—ombudsmen, legal services, in-home services, transportation, etc.—the nutrition program alone represents 66 percent of the Title III total. (See Chart 1.) Within the nutrition program itself, the $600 million, the congregate program represents the largest share of nutrition funding in 1991. The congregate meals program represents about 60 percent of the total of the three nutrition components. Home-delivered nutrition represents 15 percent, and the USDA commodities program represents 5 percent.

In 1989, about 244 million meals were served, and about 59 percent of these were in congregate settings; 41 percent were delivered in the home. I think this is an important point to focus on, just as an overview comment. In 1980, about 22 percent of the total meals under the nutrition program were served at home. In 1989, that percentage jumped to 41 percent. There is a chart up here that dramatically shows these data. (See Chart 2.)

Chart 1

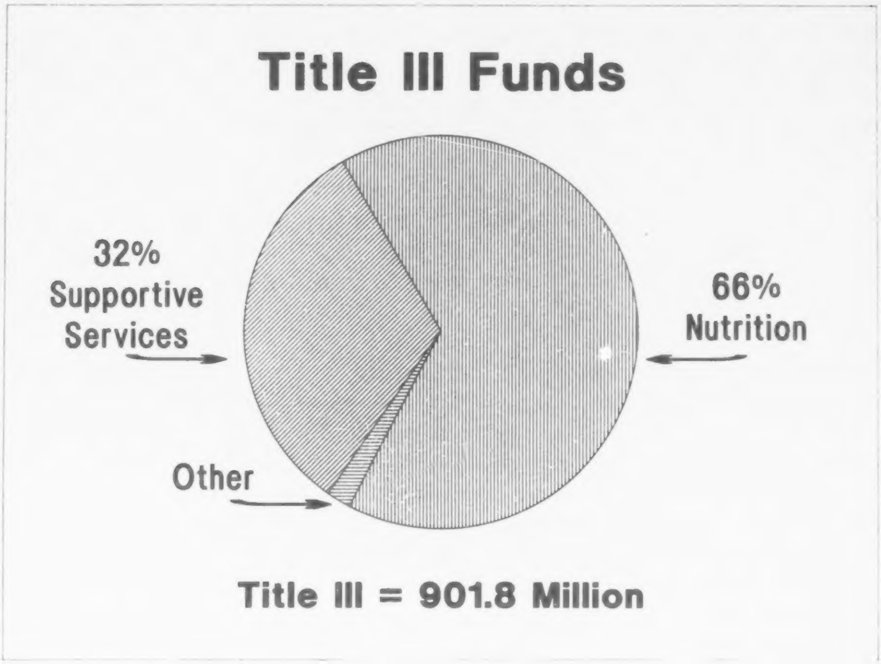
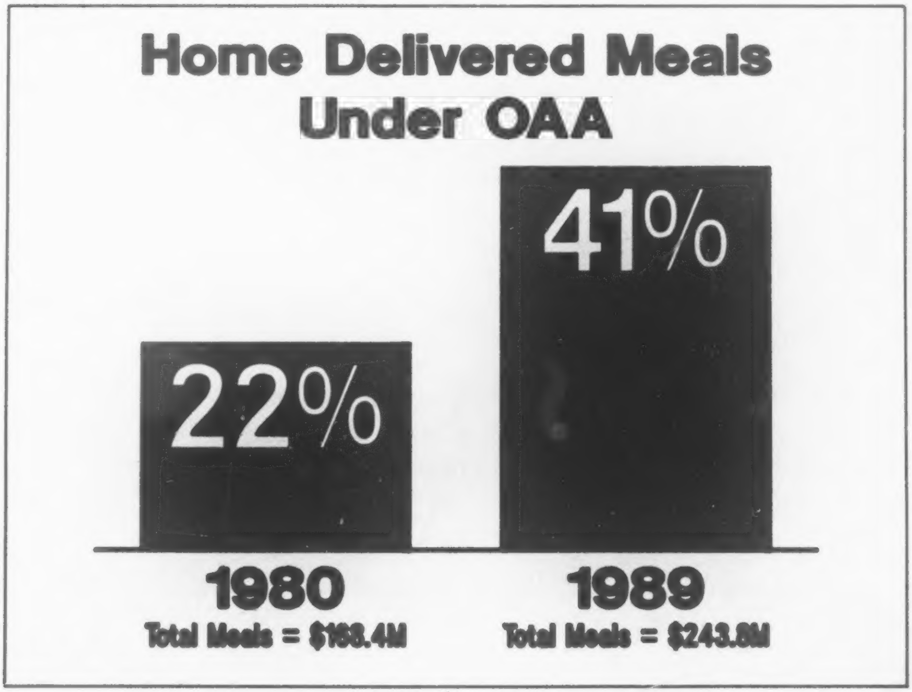


Chart 2



A number of reasons account for this fact—the demographic situation among the elderly population; there has been increased funding for home-delivered meals as compared to congregate meals, even though congregate represents the largest proportion. If you look at it percentagewise, funds have grown more rapidly in the home-delivered program than they have in the congregate program.

Another factor that I think accounts for this jump in home-delivered meals is the development of community-based long-term care systems by State and area agencies, and the home-delivered program is obviously a key component of long-term care systems.

With respect to the congregate program, we know that the aging of the population certainly has an effect on the congregate program. While we don't have national data on what the changing age characteristics are of the congregate participants, and hopefully we'll get some interplay on this later, at least we know anecdotally that the congregate participants are older and frailer than they were in the early part of the program. This factor itself may have some implications for the congregate program in terms of specialized diets and specialized health services that may be delivered in the congregate setting.

So with that said, and I hope I didn't go too rapidly over some of these points, I would like to turn to our panel, each of whom will address issues that they see for the nutrition program, now and into the future.

I will introduce the panelists in the order that they are presented on the program. I will introduce everyone at once and then turn the program over to the first panelists and we'll just go from there. These people will first give some general overview comments on the program, then on reauthorization, then get specifically into the proposals that have been put forth by ADA, NANASP, and NAMP on minimum standards.

I would first like to introduce Mary Abbott Hess, president of the American Dietetic Association; Toby Flecher, president of NANASP; John Wren, the first vice president of NANASP; Gail Martin, executive director of NAMP; and June Durham, president of NAMP.

We will start with Mary Abbott Hess.

PART I—PRESENTATION ON REAUTHORIZATION OF THE OLDER AMERICANS ACT

STATEMENT OF MARY ABBOTT HESS, PRESIDENT, AMERICAN DIETETIC ASSOCIATION

Ms. HESS. On behalf of the American Dietetic Association, it is a pleasure to participate. We thank both committees very much for inviting us.

The American Dietetic Association represents over 60,000 members. We are, of course, the largest organization of food, nutrition, and health professionals in the world today.

Among our membership there are two dietetic practice groups who have special interests in the area of elderly nutrition, the Gerontologic Nutrition Group, and also the Nutrition Consultants in Health Care Facilities.

We estimate that at the present time over 10,000 of our members are direct providers and work with the elderly in community settings such as in nursing homes. Personally, my firm, Hess & Hunt has a considerable amount of experience in working for the elderly and with elderly programs. We were the nutrition consultants for the Chicago Department of Aging and Disability for some 7 years, between 1980 and 1987.

The members of the American Dietetic Association are very interested in elderly nutrition issues. We are particularly aware that the elderly have many special needs, many of which Connie will be discussing later this afternoon. We are particularly concerned that the elderly are living longer, and many of them have chronic diseases for which food and nutrition interventions are important.

Studies have shown to us that many specific nutritional deficiencies occur in over 50 percent of independent living elderly in this country, and the diseases of highest prevalence that are affected by diet include diabetes, hypertension, cardiovascular disease, osteoporosis, and anemia, all of which have nutrition and food choice as mitigating factors.

We believe that the provision of optimum nutrition, especially through the programs related to the elderly, can help to defray the cost and onset of frail dependent conditions.

As Carol said, and we certainly agree, there is an increase in demand for services of both congregate and home-delivered meals. We certainly affirm and assert that we would like to help the elderly in this country meet both their nutritional needs and maintain their independence and dignity through the provision of services.

The American Dietetic Association believes that the Congress should act now to give OAA the support it needs to meet the demand, and we have drafted a list of recommendations for consideration during reauthorization.[2] Some of these recommendations include quality assurance. Even though nutrition programs receive over half of OAA funds, there is no one at the Administration on Aging Central Office in Washington with specific nutrition expertise. In addition, only 6 of the 10 regional OAA offices have a nutrition professional on staff, and often these same individuals have responsibilities far beyond nutrition. Many States do not have a nutritionist on staff. The employment of a registered dietitian at the Federal, regional, and State levels, and even at the program provider level, could help to ensure quality nutrition programs.

The second area of concern that we have relates to nutrition program standards. ADA strongly believes that there need to be standards developed that will ensure that the program provides the highest quality service at the lowest per unit cost to those most in need. ADA has joined NAMP and NANASP in a precedent-setting effort to draft a list of what we believe are minimum standards that are needed to assure quality programming.

Some individual States have taken additional initiatives to develop detailed standards for their State nutrition programs. I do, however, say "some States." There are many States that do not have adequate standards to ensure high quality, safe, and low-cost nutrition services.

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[2] See appendix, p. 62.

The third area of great concern to us is that of health promotion. ADA encourages Congress to continue Part F of the Older Americans Act, Preventive Health Services, which includes health promotion activities and provides adequate funds for it. These activities cover routine health screenings, exercise programs, home injury control programs, nutrition counseling, educational services, mental health services, and other education counseling services.

Prevention, in our opinion, is one of the most neglected areas of our Nation's health care system, and ADA believes that we and other responsible health professionals should be advocates for prevention.

Presently, health care delivery is directed at disease treatment rather than at risk reduction, disease prevention, or health promotion. The opportunity to reduce risk, and thus lessen the need for institutionalized care while improving independence of older Americans, is our goal.

To summarize, nutritional well-being is an integral component of health, independence, and quality of life. Preventive and supportive nutrition services can help the elderly who are aging in place, in their homes, and reduce Federal outlays for health and institutional care. Through the reauthorization of the Act Congress must express its continuing support of the optimal health and wellness of the aging population in our society.

Thank you very much for the opportunity to present preliminary comments. We will later talk about some of the joint standards.

Ms. **O'Shaughnessy**. Thank you, Mary.

We will now turn the microphone over to Toby and John from NANASP.

STATEMENT OF TOBY FELCHER, PRESIDENT, NANASP

Ms. **Felcher**. Thank you, Carol.

I would like to take this opportunity, on behalf of the more than 600 members of NANASP, to say thank you to both committees for this wonderful occasion to sit with our colleagues and discuss the issues that we feel are tantamount to this reauthorization. The elderly nutrition program needs us desperately to look at it and make some new suggestions. In that light I would like to thank my colleagues from NAMP and ADA who sat down together—for the first time in my memory, or anybody's memory—to come to some kind of conclusion as to what we would like to see in reauthorization around elderly nutrition. It was a very interesting and worthwhile experience and I want to thank them for that.

To my right is John Wren, who will be making NANASP's statement about the issues we are here to discuss today.

John.

STATEMENT OF JOHN WREN, FIRST VICE PRESIDENT, NANASP

Mr. **Wren**. Thank you. I would also like to thank the committees for this opportunity to bring forth some of the issues that our membership has brought to our attention.[3]

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[3] See appendix, p. 65.

Nutrition, as championed through the Title III congregate and home-delivered meals program, has long been a significant component of the Older Americans Act. In purely financial terms, Title III C comprises almost $450 million of planned expenditures in 1991. That's over 56.5 percent of total dollars allocated.

In human terms, nutrition programs reach the greatest number of seniors of all Older Americans Act programs. Accessible to the elderly in their own communities, the program nourishes them physically as well as socially and emotionally. Many times each day the personal visit by the Meals-On-Wheels volunteer or driver, or the interaction with others at congregate nutrition sites, is the only social interaction or contact for many elderly Americans.

Conceived to alleviate malnutrition among the elderly, the program has flourished to provide vital support to seniors, a connection to other community services, and an opportunity to enrich their lives.

The Older Americans Act is continually evolving. This is induced by change in the demographic characteristics of the elderly, as successive cohort groups reach the age of 60, and by the network struggling to redefine its role in serving the elderly. This emphasis has gradually shifted from services provided in congregate settings to individualized in-home services, and from services that are preventive and supportive in nature to those which are significantly more palliative. This shift has been accompanied by a need for a higher level of skills in the network staff. These services are also, by nature, higher in their costs.

Without meaningful increases in funding for Older Americans Act programs, this has required the network to sacrifice some objectives to achieve others. Most notably, the congregate allocation is used as "the bank" to underwrite necessary programs in other subparts of the Act. This trend has led to significant weakening of nutrition programs' ability to meet the demand for services, to assure high quality products, to employ qualified individuals, and to develop new services to keep pace with the changing client preferences. Further erosion could seriously jeopardize the existence of many programs nationwide.

In the reauthorization process, NANASP strongly urges that the transfer of funds issue be reviewed. NANASP recommends that each subpart of the Older Americans Act be adequately funded to meet its mission, and that transfers be held at their current dollar levels. Adequate resources for each subpart would end the necessity of the shell game performed with nutrition dollars. While throwing money at a problem is not always the answer, this is one clear instance where the infusion of additional funding would have meaningful and measurable impact on the condition of vulnerable elderly.

In the long term, maintenance of the nutritional status of the elderly could have significant economic benefit in health care cost containment.

Among the funding issues is the USDA reimbursement for eligible meals. This reimbursement needs to be adjusted annually to a cost of living factor in order to keep pace with food costs. Otherwise, it becomes just another way that programs are slowly eroded in their capability. Programs must be assured that the resources will keep pace with escalating prices.

NANASP also recommends that serious effort be given to develop and fund educational opportunities for staff at the service provider level. Because of economic realities, staff turnover is a problem and most programs are able to provide only minimal training. In a system where services are requiring a higher degree of technical expertise, nutrition programs need to be strengthened to assure quality of service. We cannot permit a degradation in skills at the service provider level.

Working with a population which is more at risk to food-borne illness requires a greater emphasis on education and training. Furthermore, programs must be able to respond to the special dietary needs of the elderly resulting from chronic disease, medication, and illness. This dictates a staff that is knowledgeable in nutrition issues of the aging and able to address the needs in their community.

Additional emphasis should be created on the preventive health benefits provided through balanced nutrition. The congregate program should be the major conduit through which nutrition and health education is provided to the elderly population. Serving as a focal point in their communities, congregate nutrition services provide wide access to the senior population.

Promotion of wellness is an assignment well suited to the congregate program. National and statewide efforts should be instituted to take advantage of this opportunity.

Caution should be exercised that the Older Americans Act does not shift too greatly towards a medical model. Other Government initiatives are geared to operate more effectively in this arena. The role of the Older Americans Act should be assessed carefully in order to design a system which compliments and supplements the health care system already in place and does not compete with the private sector.

It is evident that some health care services are a natural part of the Older Americans Act. Providing such alternatives to institutional care is an important function.

Great strides have been made over the past decade towards building a structure to administer such care and to assure quality. Commendably, States and area agencies are moving rapidly to address these needs, but we should avoid becoming overly restrictive and narrowly focused. We must turn our attention to the community services that underpin the system.

The past decade has had a detrimental effect to service providers nationally. Trimming of operations and staff induced by funding restrictions has left many providers in a weakened state. We must undertake the rebuilding of local capacity to meet the increasing demand. We must find new ways in which to develop public and private resources at all levels to meet the needs of the growing elderly population.

While we must concentrate on reaching seniors with greatest needs, opportunities must be afforded to those seniors to participate who can afford to contribute their time, talents, knowledge, and money. The support and involvement of a broad spectrum of senior citizens is necessary and desirable. Balance must be maintained to assure that the broadest possible support is obtained for the Older Americans Act mission. Through a sense of ownership, seniors develop and support the network instead of merely being recipients of its benevolence.

This has been the greatest strength of the Older Americans Act. The consumer-oriented focus of the Act, its emphasis on grass-roots planning, and its preservation of human dignity assure its continued success.

Thank you.

Ms. O'SHAUGHNESSY. Thank you, John and Toby.

And now June is going to address us.

STATEMENT OF JUNE DURHAM, PRESIDENT, NATIONAL ASSOCIATION OF MEAL PROGRAMS

Mr. DURHAM. I'd like to thank the committee that made this roundtable possible for us today, and also our colleagues from ADA and NANASP for the joint effort we made on the presentations.

The National Association of Meal Programs, representing providers of both congregate and home-delivered meals to persons 60 years of age and older and their spouses, makes the following recommendations regarding the reauthorization of the Older Americans Act, slated for Congressional action in 1991.[4]

The Administration on Aging data for the 1989 fiscal year for Title III C-1 and C-2 programs are presented in the table.

Additionally, in a NAMP member survey in 1989, 25 percent of the respondents received no Federal funds. Therefore, those meal numbers are not reflected in any statistics.

NAMP finds it unacceptable that the transfer of funds from the Title III C program, as illustrated in the table, has resulted in a decrease of over $92 million in funds available for meals. NAMP's position regarding funding policy is that Congress should eliminate completely transfers between Title III B and Title III C and ensure that each part is adequately funded.

There should be a mandate that AOA-published guidelines for allocation of nutrition program assistance on a unit or per meal basis is required.

Establish as an entitlement for each provider a minimum floor of assistance per meal, which can be augmented above this minimum assistance level by State and area agencies.

Require that AOA direct the State and area agencies on aging to not duplicate existing nonprofit programs.

Under training, NAMP believes there needs to be a greater communication and coordination effort with private sector programs. Therefore, NAMP recommends that more emphasis be placed on training opportunities for nutrition providers regardless of their funding source, and that training opportunities are provided by utilizing existing public and nonprofit senior meal organizations.

NAMP supports a concept of cost-sharing as a way of increasing program resources, but believes that it should be administered with certain recommendations. A Federal initiative on some cost-sharing for elderly services needs to be undertaken. A self-supporting mechanism by the client, in conjunction with the initial intake assessment questionnaire, should be used rather than a means test. Cost-sharing should be used in other elderly service programs as well, not only in those providing meals. A concerted outreach effort should be made to have senior citizens who are eligible for food stamps use their stamps for their donations.

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[4] See appendix, p. 69.

Current operational standards, practices, and procedures need to be reviewed and measured against proposed standards that are being presented. Therefore, NAMP recommends that a set of minimum standards be developed for Title III C–1 and C–2 programs that address issues including, but not limited to, menu planning, staffing, food service code conformance, staff training and development, and client assessment and nutrition education.

With USDA commodities and USDA cash, at present there is limited access to the $0.5676 per meal USDA reimbursement provided to senior meal programs for qualifying meals. This limitation is a function not of USDA regulations but those of AOA. Furthermore, the USDA reimbursement rate is subject to an authorization ceiling which in practice means that increased numbers of meals can result in a decrease in the rate of reimbursement. NAMP therefore recommends that Congress provide for broader eligibility of senior meal programs for commodities or cash in lieu of commodities by imposing only the following criteria on local providers for them to qualify for the UDSA assistance:

> They must be nonprofit or public agencies;
>
> They must serve meals which comply with nutritional standards as stated in the Act, currently, one-third RDA;
>
> They must serve meals to those 60 years of age or older or their spouses, and all others as specified by the Older Americans Act;
>
> They must agree to audits of these above by State units or area agencies on aging, and maintain records showing compliance; and
>
> They must provide that the level of assistance per meal be indexed to the Bureau of Labor Statistics cost of food away from home, and that this per meal assistance be re-cast legislatively as an entitlement.

Further, and finally, the status of the Commissioner on Aging—the Older Americans Act should be amended to elevate the position of Commissioner of the Administration on Aging to Assistant Secretary within the Department of Health and Human Services.

Thank you.

TABLE 1

	Title III C–1		Title III C–2		Total
	Congregate program	Percent	Home delivered program	Percent	
Unduplicated persons served	2,763,273	(78)	775,159	(22)	3,538,432
Meals	144,112,450	(59)	99,686,266	(41)	243,798,716
Appropriated dollars before transfer	356,668,000	(82)	78,546,000	(18)	435,214,000
Amt./meal before transfer	$2.475		$.788		$1.785
Allocated dollars after transfer	233,672,472	(70)	101,475,482	(30)	355,147,954
	[1]		[2]		[3]

TABLE 1—Continued

	Title III C-1		Title III C-2		Total
	Congregate program	Percent	Home delivered program	Percent	
Amt./meal after transfer	$1.621		$1.018		$1.375

[1] $240,023,764 including education/training ($1,932,549), outreach ($3,481,815), and transportation ($936,928) related to nutrition program.

[2] $102,821,487 including education/training ($441,375) and outreach ($904,630).

[3] $342,845,251 if the services in [1] and [2] above are included in our NAMP member survey in 1989—25 percent respondents received no federal funds. Therefore, these meal numbers are not reflected in any statistics. 50–60 programs.

Ms. O'Shaughnessy. Thank you, June. Lots of wide-ranging proposals for consideration in reauthorization.

Now we'd like to turn to a discussion of what the three groups have developed. I would like to turn first to John, who is going to be discussing part of the standards. The three groups have divided up their discussion.

Mr. Wren. Thank you.

The American Dietetic Association, the National Association of Meal Programs, and the National Association of Nutrition and Aging Services Programs strongly recommend that the following standards be incorporated in the Older Americans Act. As service providers responsible for program implementation, we believe these minimum standards must be established at the Federal level. The weight of law helps assure that the largest number of high quality, nutritionally adequate meals will be served under safe and sanitary conditions at the lowest possible cost.

Our continued interest in meeting the nutritional needs of older Americans will reduce the end costs of health care, as well as improve the quality of life. Adequate funding should be provided in all cases to accomplish these minimum standards so that no loss of meal service to older citizens occurs.

First is that meals shall incorporate the U.S. Dietary Guidelines and meet a 5-day time averaged intake of one-third of the daily recommended dietary allowances, as established by the Food and Nutrition Board of the National Academy of Sciences' National Research Council. If multiple meals are served each day, the combined meals must meet two-thirds RDA for two meals, and 100 percent for three meals.

Underlying all uses of the RDAs is the recognition that humans are highly adaptable. Throughout its existence the human species has developed regulatory and storage mechanisms that will permit it to survive in a variety of environments and to withstand periods of deprivation. These basic biological considerations, coupled with the fact that the RDAs include reasonable margins of safety, are the overriding considerations that should guide the user in applying the RDAs in specific situations.

Experience with uses and misuses of the RDAs has indicated that certain areas require emphasis and clarification. The terms "per day" and "daily" should be interpreted as average intake over time. For most nutrients, RDAs are intended to be intakes over at least 3 days; for others, they may be averaged over several months.

Menus should be planned to take into consideration ethnic, cultural, and regional preferences, especially as expressed by each nutrition project's Senior Nutrition Advisory Council.

The second recommendation is that nutrition education should be provided on a quarterly basis to all participants in the C-1 and C-2 meal programs. Nutrition education is the process by which individuals gain the understanding, skills, and motivation necessary to promote and protect their nutritional well-being through their food choices. The materials provided must be accurate and appropriate to the audience and provided by registered dietitians and/or staff who receive guidance from a registered dietitian.

Ms. O'SHAUGHNESSY. Thank you, John. Gail is now going to talk about standards recommendations 3 and 4.

STATEMENT OF GAIL MARTIN, EXECUTIVE DIRECTOR, NAMP

Ms. GAIL MARTIN. Good morning. It is also a pleasure to be here.

Moving right along, number 3, State Units on Aging must develop training guidelines to assist Area Agencies on Aging and nutrition program providers in developing and implementing appropriate regular and ongoing training of all aging network nutrition program employees and volunteers. I will give you some of the rationale and comments, very briefly, on why we came to this conclusion.

Professional staff and volunteers need to be actively engaged in ongoing training to ensure the most effective management of a nutrition project. Areas of critical importance for development include, but are not limited to, management of food service operations, either catered or central kitchens; effective use of USDA commodities and other donated foods; food safety and sanitation; community resource development; purchasing for cost control; the role of nutrition in long-term care; and associated nutrition and health issues.

Number 4, State Units on Aging must develop minimum assessment criteria for the determination of participation in the Title III C-2 program. The criteria developed must include a re-evaluation period to determine the need for continued participation by clients and should take into consideration the participants' need for other services.

In order for homebound older persons to remain independent and in their own homes as long as possible, their eligibility for home-delivered meals and other appropriate services must be assessed. The assessment should focus on a variety of factors including, but not limited to, target population of frail elderly poor, minority poor, functional level of mobility, both physical and mental disabilities, general health, nutritional need, family support, isolation, homebound, lack of transportation, and other factors. The home-delivered meal is often the entry point for other needed services.

The purpose of reevaluation is to evaluate the participant's general and nutritional well-being and to determine whether the need for home-delivered meals still exists.

That's it. I've done my two. Still, I've looked at this document and there are seven. Mary Hess is now going to read 5, 6, and 7.

Ms. Hess. This is a bit like the swim meets where you do the hand-offs. She has touched her side so we're on ours, and our standards to present are 5, 6, and 7.

I would like to ask the Committee to officially include in the record the exact wording as provided in the recommendations submitted in writing. Therefore I will discuss their content more generally.

Joint recommendation number 5 deals with minimum assessment criteria. The group believes that determining the participants' social needs and needs for nutrition assessment is important in terms of identifying what nutrition social services are needed, and it is the belief of the three organizations that funding for these services is inadequate at present.

There will be time this afternoon to discuss some of the assessment and screening mechanisms that are being advocated.

The sixth recommendation has to do with staffing. It is the joint recommendation that a minimum of a full-time registered dietitian shall be employed by the Administration on Aging at the Central Office and at each regional office and by each State unit. The identification of the functions is provided in the joint recommendation.

We believe there is a need for nutrition expertise in program administration for cost control and a number of other reasons. Regional nutritionists should be available both for technical assistance to State programs, and they must have the budget in order to travel and administer and coordinate these kinds of programs in order to be effective. It is our understanding that at this point in time that such a system is not in place. There are not enough regional people, and they do not have the budget to do the kind of job that we would like them to be able to do.

The seventh standard says that nutrition providers must conform to Public Health Service codes and State and local laws, and then proceeds to talk about the specifics of storage, preparation, and service. It is the basic point within this recommendation that safety of the food that is provided in all the senior eating programs is of paramount importance; and because the population served is at risk, that food which may be marginally safe or healthful for younger populations may be patently unsafe for these populations. Clearly there must be considerably more attention both to the training and standardization to protect the public and participants in the program from food-borne illness. The issues of microbial contamination and other food safety concerns can lead to major public health problems should these standards not be maintained. We see great variability within the States and program providers in how well these standards are maintained and enforced. Certainly, there is not enough training in this area.

Without the specifics of the words, I ask that the recommendations be officially inserted into the record.

Ms. O'Shaughnessy. The words will be officially inserted into the record. Thank you, Mary.

At this point we are goint to turn the discussion over to you for interaction with the panel members. But just to start this off I would like to ask a general question and have any or each of the panelists respond as they wish.

As we said earlier, this program existed for almost 20 years. It represents the largest portion of Older Americans Act funding. We have a situation where the Federal regulations are minimal. Basically, the Administration has taken the point that the law stands as such and that regulations will not reiterate the law.

I would like to ask the panelists to respond on how they came to the development of these minimum standards. What are the issues that they see? Obviously they see the need for training and more staffing. However, the program has been around for 20 years. Is it a situation where the program runs itself? It's got people who know what they're doing; obviously, from their point of view they think there is need for more training, more staffing, more standardization.

What is a typical kind of situation with respect to staffing and training at a State level, so we can sort of understand how the three groups came to their crystallization of these standards?

Ms. **Felcher.** It pains me to say that 3 years of training has been cut to a minimum. We are concerned at NANASP at the very little training there is. If it were not for each major organization doing their own yearly conferences and some State providing a minimum of training, there would be no training going on at all.

The thing that really concerns me at this point in time is the lack of travel money that is available so that now, at these conferences where good training goes on, where prople can network, where one can get best practices and ideas, where they can share their joys and successes and their problems, we are hearing from the field that that kind of travel is going to be minimal.

I think that is a critical issue. If this keeps up, then the quality of staff that we have at our nutrition sites, running our programs, project directors—we see it already—is being diminished to the point where there are people who really don't understand what it is they are supposed to be doing.

We are greatly concerned about food-borne illnesses. We are concerned about people who don't know what the Older Americans Act means. We are greatly concerned about people who don't understand the aging process. If we keep cutting back it's a death knell for the programs that we have grown to respect and love and have a great sense of responsibility for.

Carol, I think that's the answer to the question, but you alluded to how we came to these standards. Well, we just all sat around the table and started talking. We talked and talked and we shared with our colleagues across the country and got input from our executive boards and from our memberships, and two national surveys that had been taken during the year.

As I said in my opening remarks, I think this is an historic moment that we can sit around the table like this and share these problems. I would hope that we can come away with some understanding and some sense that we will continue working on these problems together rather than separately.

Ms. **Gail Martin.** In looking at the minimum standards, in the timeframes we had to put them together, we certainly could have gone into a lot of detail in a lot of the areas. But we really looked at four major areas, and each of the seven items included in the minimum standards paper fits into one of these areas.

(1) Menus: How they fit into the total program as we look at it.

(2) Staffing: Is there adequate staff out there to turn to, whether it's at the State, regional, AOA, or provider level? Who do you turn to when you have a new person coming in for technical assistance and so forth?

(3) Safety and sanitation: An obvious problem. We could tell you some of the horror stories as well as some of the successes in that.

(4) Training: There has been a high turnover of staff, but also the oldtimers have been there for 20 years and need remotivating and need to look into new technologies. The newer people, obviously, need training from the bottom up.

NAMP had an extra area that we wanted to read on our own on the minimum standards, and if I may, I would like to do so now.

This is again on the menus, and there is little rationale for that. I don't know if you picked it up; it's a single page, over on the table.[5]

The menus must meet one-third RDA, as verified by means of nutritional analysis, unless an exception is granted to a program by a State Unit on Aging. The reason for that is that the goal of verifying the minimum standard of one-third of the RDA is accurately accomplished by a nutritional analysis. Standard computer programs are already out there and available and not terribly expensive. You can also write your own program, which I did almost 15 or 17 years ago, using the nutrient standard method. It's a lot of work but once it is in place it is in place forever unless the RDA's change.

The meal pattern, which was originally meant as a guide, has often become the rule. One of the reasons for this—we felt strongly about this—is because of predominantly the 3 ounces of edible portion protein on the plate. In the menu guide, that is what is stated, with two half-cups of the vegetables and fruit and so forth.

In reality, many programs probably aren't putting the 3 ounces of protein right in the center of the plate. In casseroles, it doesn't necessarily occur. It is the most costly item. It adds fat to the diet, and many of the States individually are looking at perhaps lowering that protein amount to 2.75, 2.0, 2.5—we knew we could never get a consensus in this short amount of time on what it might be. California is looking at 2.5 ounces. So that was one of the reasons that we felt strongly about this.

Ms. O'SHAUGNESSY. Thank you, Gail.

Anyone else on the panel?

Ms. HESS. Yes. I wanted to make it clear—you asked about how the group came up with these standards when they sat down to talk. I would like to reassure everyone that the group was trying to identify minimum standards, and that these are the core issues that have to be addressed as the highest priority. Were we given the charge about what would make an ideal program, we would probably have many more standards at greater degrees of specificity.

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[5] See appendix, p. 72.

But in addition to these joint standards, the American Dietetic Association has two additional standards that I would like to share for the record.[6]

The first is, in consultation with geriatric nutrition experts, State Units on Aging, Area Agencies on Aging, nutrition program providers, and professional organizations such as those represented here today, that the Administration on Aging should research and develop guidelines that would integrate additional following services into comprehensive nutrition therapy intervention for special needs populations. Those areas are nutrition screening, nutrition assessment, nutrition care planning, nutrition and therapeutic diet counseling, therapeutic meals, meal supplement, and meal replacement products.

The reason for this additional recommendation is that clients' needs are becoming more complicated, especially since the DRG's were instituted. We are seeing elderly being released from hospitals sicker and frailer and with many more medical needs. And we are seeing that, since this is part of the population served, meal service alone is not enough to address many of the participants' needs as they are currently released from the hospital.

The second additional standard that the American Dietetic Association endorses is that health promotion programs shall include nutrition counseling and education services by registered dietitians as a core component, and adequate funding should be provided for these services.

The basic notion here is that a large portion of the elderly are healthy and independent and want to stay well and functioning as long as they can. We believe that, given the tools to do so, this will be a very positive action on their behalf.

We believe this information should be an important part of the health promotion aspect of the Administration's program. We are very interested in providing additional nutrition information and counseling as an intervention so that individuals may maintain control of their health and remain mobile and active in our society and not require hospitalization or institutionalization.

These are two additional standards that we would like to include in the record.

Ms. O'Shaughnessy. Thank you for that explanation of how you came to the minimum standards and what problems and issues you see in the field.

At this point I would like to turn it over to members of the group who are sitting with us here at the table to see what additional comments you have, what questions you have for the panelists, any particular issues you would like to raise. When you are doing so, please just raise you hand and identify yourself and the organization that you represent so that this can be recorded in the transcript.

Yes?

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[6] See appendix, p. 73.

STATEMENT OF COLLEEN PIERRE, DIRECTOR, BALTIMORE ELDERLY NUTRITION PROGRAM

Ms. PIERRE. My name is Colleen Pierre. I'm a registered dietitian, and I am also the Director of the Elderly Nutrition Program in Baltimore City.

I would like to address the first item on the list, the joint statement, inclusion of the U.S. Dietary Guidelines, and a change in the way we use the one-third RDA.

I would like to start off by saying that initially the focus of the Older Americans Act was a prevention program for the well elderly. Over time we have seen a tremendous shift in focus toward the frail elderly. On the one hand that is good because it shows that the nutrition program that we started, in feeding people, has worked. We created a population of people who now need another kind of care.

It would be foolish of us to allow the shift of money to keep going in that direction. It's like eating your seed corn. If we keep shifting the money to feed only the frail, then we lose the advantage of prevention in feeding the well.

As a registered dietitian and as a person who operates in the field, dealing with an increasingly frail population, I recognize the need to meet the nutritional needs of those people. But I think we have to be very careful in turning loose our prevention money. If we agree that we need to take care of the frail elderly, then I think we also need to agree to seek some additional funding, and perhaps a different subtitle in which to do that.

In looking at the actual nutrition standards that are in the Older Americans Act, we've only ever had one standard, and that was that the meal had to meet one-third of the RDA. In the past 10 years we have had an incredible consensus among nutrition professionals that there are other standards that everybody, not just the elderly, need to meet, and those are codified in the U.S. Dietary Guidelines. One can meet one-third RDA or two-thirds RDA and provide a very inadequate and unhealthful diet.

I think it is crucial, if we do nothing else in changing the standards, that we get the U.S. Dietary Guidelines included as a piece of the Older Americans Act, because they do represent the best that we can come up with right now for everybody. In including the U.S. Dietary Guidelines we do get to focus on fiber and cholesterol and reducing sodium, and a lot of the changes that it would make in diets that we are actually providing would begin to take care of a lot of the therapeutic-type diets that we need to provide. Although they wouldn't be as fine as something that came out of a hospital kitchen, they certainly would move in the direction of providing a diet that is going to help to manage most of the chronic diseases that we see in the population.

The other thing that the information does underscore, and I think we need to look at it rationally, is that one-third RDA doesn't mean that each and every meal has to have one-third of the RDA, and that really throws a kink in the works when you're dealing with menu planning if you feel you must meet that standard in every meal. For dietitians dealing with hospital patients, we know that the turnover rate is every 3 days or every 5 days, so menus can be very limited. But with our population we've been feeding the same people for 15 to 17 years, and it really makes it difficult to plan menus when you are too confined. It is a confinement that is totally unnecessary. The information that is provided on time averaging comes from the handbook that is provided with the RDAs. Those are the instructions for how to use the RDAs.

So when we get into implementation, we need to be a little bit careful about how we do that.

Thank you.

Ms. O'SHAUGHNESSY. So you support recommendation number 1.

With respect to your first point about the original intent of the Older Americans Act, of course, the intent was to provide meals and to provide social services. I think just the fact that the demographics have taken over the situation—you can see on this chart here,[7] just to bolster what you're saying—now we have 41 percent of the meals delivered in home settings. We presume that these are frail older persons who cannot get out to go to the congregate site. I think it just reflects what is happening in our society in general, that aspect of the population becoming more frail.

I think you also have to realize that we're dealing with one funding source here, the Older Americans Act. The funds have shifted to support home-delivered meals. There are other funding sources, obviously, that provide services to the long-term care population.

So the point that you are raising really raises a whole host of other issues with respect to long-term care policy.

Ms. PIERRE. Just a comment along those lines.

One of the issues that has been discussed among providers across the country over the last few years is the fact that we have indeed shifted. We know through studies that we've done that the average age of people we're serving is around 75. We all keep asking each other, where are the younger old?

In my program this year in Baltimore City we made a change in the way we provide meals. We found that a lot of our seniors live in high-rise buildings, and we are providing a noon meal. We had situations in which attendance was falling off, so we shifted to an evening meal. The reason we shifted to an evening meal was because we found that many of the younger old are still working or they are providing child care for their own children and grandchildren and great-grandchildren, and they are not around at lunchtime.

When we shifted to an evening meal, our attendance at those same locations doubled. Many of the people who came were men.

We shifted into a preventive mode very quickly. It is true that the population is getting older and it is true that we have to take care of those people, but it's also true that we need to be creative in making sure that we are providing that nutrition product to people who need it now in a way that is going to pay off in the long run.

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[7] See chart 2 page 4.

STATEMENT OF NANCY CHAPMAN, SOCIETY FOR NUTRITION EDUCATION

Ms. CHAPMAN. Thank you. I am Nancy Chapman. I am the Director of Public Policy for the Society for Nutrition Education (SNE).

I wanted to begin by thanking Ed Barron and Heather Burneson and you, Carol, for assembling this group, and congratulate NAMP, NANASP, and ADA on coming forward with such pertinent standards at this time.

SNE has identified similar issues. We have a sheet on the back table which we would like to provide to you. If anybody wants it and it's not back there, we can provide copies of it to you.[8]

What we would iike to do is to reserve the right to add a little bit more into your hearing record.

Ms. O'SHAUGHNESSY. Yes. As I mentioned before, if you have further testimony to submit to the committees, it will be incorporated into the record later.

Ms. CHAPMAN. We would like to identify four issues that sort of amplify some things that were put forward earlier.

One of them is that we believe that nutrition and fitness education and counseling should be mandated as a separate line item under Title III C and required in both the congregate and home-delivered meals programs. This just follows on to what was previously said, that we have something very specific in the form of a mandate.

We also believe that these nutrition and fitness programs should be designed to meet the diverse needs of the nutritional statuses and living situations of older Americans. I think we've seen that the most effective nutrition education is that which is most responsive to the target audience.

A second provision that we would want to make sure gets into any type of legislation is recognition that the Dietary Guidelines and the related USDA materials designed for older people—I don't believe they're out yet, but they're in the planning stages and should be out soon—should be made available to all participants in Title III meals program. We have excellent text in the Dietary Guidelines and in the new USDA material now that should be used more aggressively to serve as a foundation for nutrition education materials.

The third has to do with the reference in terms of the kinds of credentialing that you would require for these older American programs. I do recognize that you want to have credentialed nutritionists working. We have suggested you use the word "credentialed nutritionist" instead of "registered dietitian." There are many members of the Society for Nutrition Education who have a master or doctorate degrees in nutrition with very similar education and very similar training to that which members of the American Dietetic Association have, and we share many of the same members, in fact, in our organizations. But there are some members of SNE who have elected not to go for a registered dietitian certification. So we would like you to look at the use of that word more broadly, but we do understand that we need credentialed people with adequate training and education.

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[8] See appendix, p. 74.

The fourth is an issue that was debated, I think, when this was reauthorized before, and we would like again to just assure that the service providers in the programs under Older Americans Act inform the participants about other nutrition and social program benefits to which they are entitled. This is an issue because many older people are entitled to additional food assistance and access to other social programs, but sometimes they're just not aware of those benefits. We believe it would be very important that providers understand the benefits of food assistance and understand how to enroll people in those programs.

So we thank you again for the opportunity to present these remarks.

Ms. O'SHAUGHNESSY. Thank you.

Other questions or comments? Paul.

STATEMENT OF PAUL KERSCHNER, NATIONAL COUNCIL ON AGING

Mr. KERSCHNER. Thank you. Paul Kerschner with the National Council on Aging.

I wanted to sort of back up what Colleen was saying. One thing, I think this should all be placed in context. If you look over the 20 years since this program started and if you look at what the major intent was behind then-Title VII, now Title III, meals programs, it has shifted. It was originally socialization, keep down premature institutionalization, and then nutrition. As the population aged and you saw more and more frailty, nutrition became higher and higher up in the equation.

But I think the meals program is the one vehicle in the senior center, for example, that can bridge the gap between the young old and the old old. It can be used for nutritional purposes and socialization purposes, and for entry into other programs, whether those be health promotion or other kinds of services. I think that when the reauthorization comes up we need to make clear our intent to Congress that this program is more—in addition to all the nutritional issues involved, which we all support, it is also a way to ensure that the well elderly and the frail elderly can be served in the same population. You can keep people productive, you can do some restoration, you can keep people from entering institutions prematurely.

Ms. O'SHAUGHNESSY. Thank you, Paul.

STATEMENT OF NANCY WELLMAN, NUTRITION SCREENING INITIATIVE

Ms. WELLMAN. I am Nancy Wellman, speaking on behalf of the Nutrition Screening Initiative, and I am also representing the American Dietetic Association as one of the three lead partners in the Nutrition Screening Initiative.

I know that we have many colleagues around the table because there are 35 national organizations that are involved in this coalition.

We support the minimum standards that have been put forth by the associations that have been speaking, and in addition we must emphasize that we need to reach an even greter number of older adults. In particular, we need to add nutrition assessment to the list of nutrition program support services. We believe older adults should be assessed or screened periodically during their time within the program in order to better assess the distinct nutritional needs of each and every meal program participant. We're not talking here about a means test; in fact, we're talking about tracking the nutritional status of the science that the program is serving. We are also trying to document the differences that the meal program makes in the nutritional status of the participants. So we think that the screening would do a lot to do some program evaluation there.

We also need to reach those seniors who are not currently served through the congregate or home-delivered meals program, and this has been alluded to by a number of people this morning already. We have to increase the level of participation in the OAA-supported meals program, especially by those seniors who are particularly hard to reach. I think we are all concerned about so many of them who are falling through the cracks. Many of our people can't get to the sites because they don't have transportation. Sometimes the most needy are the ones who are getting the least because they're the least involved in the program. So we suggest that this population, the most needy, be targeted in the future.

We do feel that by including a nutrition assessment or a nutrition screening in the program support services, that we would be better able to identify these types of individuals who are most at need and at risk. Why do we think that this will happen? It's because we see screening for nutritional status taking place in many sites in addition to the congregate meal program or in the home of the elderly who are being provided with the meal. We see this screening taking place in the family physician's offices or other physicians' offices, adult day care, and any other place where the elderly are likely to come in contact with a system.

I think perhaps my colleagues from the American Academy of Family Physicians and also the National Council on Aging would like to add some more comments about the Nutrition Screening Initiative.

STATEMENT OF DR. GERALD KELLER, NUTRITION SCREENING INITIATIVE

Dr. KELLER. Certainly I am here representing the Nutrition Screening Initiative, but I also would like to just offer some comments as a practicing physician for 30 years. The area in which I settled and where I now practice was rural, then became semi-rural, and now has become somewhat suburban.

I think the program as a whole has been a tremendous asset to us in family medicine and to our patients. For many years when I first went into practice we were always concerned about those people who were nutritionally deficient. Certainly, we found that a large problem among many of our patients.

The congregate meal programs as well as the home meals have been a tremendous help to us in the care of our patients and those we can identify as not only needing adequate nutrition at home, but who do not have the support to obtain that adequate nutrition.

My only concern, as Nancy has said, is that it's just not far-reaching enough in many aspects. I see many of my patients who attend the congregate meals who certainly need that type of thing for the socialization and to get adequate nutrition. Many of my older patients frequently don't want to cook, so they don't cook adequate nutritional meals. Congregate meals provide a means of getting adequate nutrition, yet I also see some of these same patients as being able to afford to pay better for this adequate nutrition. I do find that some of my patients—not because they're frail, but because of lack of transportation and support from their own families—are unable to get to congregate meals, and probably either need more transportation to these places with expanded programs, or more Meals On Wheels types of programs. It's not because they're frail but because of their support systems not being there, enabling them to get to these types of programs.

I see that many of my poor patients do not avail themselves of the programs because they are not aware of them, we haven't reached them and informed them, and haven't facilitated them getting to these programs. Part of that is our fault, the physicians' fault, and part of it is because maybe we're not educated as to the availability of these programs. So I think we need better coordination between the physician and the programs to facilitate whether our patients are in need of this program, and particularly, what special diets they may need.

I don't disagree with you when you talk about prevention. I think prevention is extremely important, as witnessed by the U.S. Services Task Force on Prevention and Healthy People 2000. I think prevention is extremely important. On the other hand, as also said, we are discharging people much earlier from hospitals because of DRG's. Many of our patients do need special diets, so we need to reach more of our patients. In some of my rural areas they are 20 miles from the nearest city, and no one is out to service them 20 miles from the nearest hospital.

As Nancy said, I think we need to be screening these patients to identify what their particular nutritional needs are, and we need to service them.

I have heard this one-third RDA mentioned several times. I can tell you what happens among my elderly patients. They save part of their lunch to eat at supper. If all we're going to serve is one-third, they're only getting one-third, because breakfast is a piece of bread and a cup of juice or a cup of coffeee, and supper is what's left over from lunch, so they're not getting adequate nutrition because they're just not getting three meals each day. Maybe they can't afford it, maybe there's no one to cook it, maybe there's no one to bring them to the grocery store to buy food. I have seen them eat part of Friday's meal on Saturday. I'm afraid the one-third just isn't going to cut it for most of our older patients.

Ms. O'SHAUGHNESSY. Thank you.

Both of you touched on something that I've talked to other people about. We've got the situation where we have a need for outreach for the program. People have said this, that we need to identify those who could best be served through the programs. So there is a need for outreach to get those who are not served, and we do have incidents of waiting lists in certain parts of the country. On the other hand, there is also some anecdotal evidence that there is some closing of nutrition sites.

Toby is shaking her head here. I think I know what she's going to say, but if people would talk about this issue, waiting list versus closing of sites, and what's happening in terms of the distribution of the program, what's happening with the congregate program and the type of person served there? Are people really going into the home-delivered program?

Toby.

Ms. **Felcher**. Well, the juices are starting to bubble.

It's more than anecdotal, Carol. We have just released a survey, taken across the country of our membership—it's just our membership—and we have come across some alarming statistics. I agree with Nancy and Dr. Keller. All the things that you are suggesting are critical. But I'm going to speak to you now from the real world of service providers.

We are hurting. We are hurting because of funding. We are hurting because nutrition project directors have cut back as much as they can cut back. We have cut staff down to bare bones. We would love to do outreach. We don't have people to go out and reach out. That's the real world.

I think I'm going to ask John to comment on the survey because John was very instrumental in putting together the survey and then collecting the data. It was not scientific. We don't have the money or the time, because we're busy providing meals on a daily basis. But it was an eye-opener for us.

John, do you want to address that survey?

Mr. **Wren**. I don't have the information with me at the moment as far as the number of sites, but it was a significant number. We had sent a survey and got better than 273 responses that covered 48 States that had responded to the questionnaire.

We only asked six questions. They were about what their status was in 1990; what their planned status was for 1991 as far as the number of sites, whether they were closing sites or whether they had waiting lists. I believe it came out that about 20 percent of the programs that reported back said that they had closed sites in 1990, that they planned to close sites in 1991, and that they had significant waiting lists.

There are also communities in their areas that aren't served, even though we do have a congregate nutrition program that has been around for a number of years; there are still geographical areas within, I know, my own county where we have no nutrition coverage at all by way of a congregate nutrition site, so other individuals have no access to the program.

It was stated that the information is being released. Hopefully it will be published and we could have additional comments on it.

As to screening, I know anecdotally that my program is about an average-sized program, about 1,100 meals per day, roughly split between congregate and home-delivered. We have one licensed social worker who has the task of doing semiannual assessments on an average client load of 500 meals per day. During the course of the year that's probably in the range of 700 to 750 clients, and that's just physically impossible, to get adequate information and planning for each of these individuals. But our program has sacrificed by way of personnel and salaries and things of that nature in order to maintain the meal count.

We have a nonprofit board that runs it. One of the things they take pride in is the fact that although we are receiving $80,000 less this year than we received in 1982, we still have been able to maintain services. Unfortunately, I think that has come at a significant cost by way of the quality of service that we're able to provide. We really need to address that.

Dr. **KELLER**. Carol may I just comment?

I hope no one interpreted me as saying that I am displeased with the program. I think the programs are great.

Ms. **O'SHAUGHNESSY**. No, that came out very clearly, that you were very pleased.

Dr. **KELLER**. It's not that. I feel that they should be expanded to include more people, more outreach, and more screening. It's not that I'm not pleased with what's going on.

Ms. **FELCHER**. No, Dr. Keller, my reaction was not that you were displeased. We are agreeing with what you're saying, but we just don't have the resources to do it. You are right on the money as far as I am concerned, and Nancy also, but we are just making a plea here for more resources.

Ms. **GAIL MARTIN**. Okay. First of all, I think this Nutrition Screening Initiative is going to be very important because we don't know how many elderly out there are malnourished. The meal is really the cheapest form of therapy, if you can call it that, of anything you could do, and the socialization is free. I think that's important.

The waiting list—you know, you have data and we have data, and congregate is having problems. No doubt about it. And home delivery is the real trouble. We took a survey at NAMP 2 years ago, in 1989, and found that the average waiting list nationally per program was about 70 people per program, and in specific cities, going up to—Dick, how many in Buffalo?

Mr. **GEHRING**. At one time we had a thousand.

Ms. **GAIL MARTIN**. A thousand on a waiting list. But they could average as much as 200 to 400 people.

I think what we have to address here, and we would all be in agreement, is that all of these services are needed but that we have finite resources. So how do we determine who gets what? The ones on home-delivered meals, although we try to move them back into congregate when they are well, and I think with the minimum assessment forms and the reevaluation and these minimum standards, we may be able to help programs, to say, "I'm sorry, you've got to come back into a congregate program." That needs some work. But the majority of them, when you are out there, they are very, very frail. There are more of them, and they need the meals.

Basically, I think that's what we've got to look at. With the limited resources, how do we make the decision? Is it going to be like an acute care model for those very, very frail, 85 and above, on home-delivered? Or indeed, as we have all said, keep the wellness program, the health promotion going, because that's also important? That's why NAMP took the kind of forward-thinking philosophy in its testimony of saying—and I'm going to use the analogy of the Bell Telephone Company; when they first started, they said, "We want universal telephone service in every home." That was their goal. And they succeeded, although they may have some problems right now, but that was their goal. And the school lunch program did the same thing. They said, "Every child has a right to have a meal in the school setting." They have accomplished that. It is an entitlement, and it is broken down into free, reduced, or paid. So all children have an opportunity for that.

That's why we feel the same way with the elderly. It's hunger, folks, it's not just a program and a social service; it's hunger out there. I know right now, with the American electorate and with Congress and all of us, we're not at the right crossroads to say that this should be an entitlement, but indeed it should be.

Ms. **O'Shaughnessy**. Thank you, Gail.

I think that's a point to reiterate. This is not an entitlement program and we are living in an era of budget constraint. I think everyone in this room knows that.

Dr. **Kerschner**. Carol, I don't want to throw in the towel. What I'm worried about is that the aging groups are going to throw in the towel on this.

I don't think it can come out of the individual sites. I think you are doing everything you can to target and to do everything else.

If we have to call for a doubling of the Older Americans Act moneys, then we should do that. I think we need to put more money into it. If it's for screening or if it's for going after the frail or for the old-old, the only way that's going to be done is to put more money into it.

One of the reasons the school meals program worked and the phone in every home worked is that they turned to more than just the choir. They turned to the rest of the community. We need to turn to the women's groups—not OWL, but NOW. We're talking about the over 85, and 90 percent of those are women. We're talking about the disability groups, we're talking about the children's groups, Kiwanis—it's their mothers that are being fed there—and we need to try to put together a coalition to say, "We're talking about food, folks. We aren't talking about legal services, we aren't talking about advocacy; we're talking about giving people meals." Then you begin to get a coalition built up that says to a Congressman, "Are you really turning down Mrs. Smith's lunch?" That gets to the heart of what this country is all about, and I think there's a chance to do that.

Ms. **O'Shaughnessy**. Thanks, Paul.

STATEMENT OF CONNIE CODISPOTI, OHIO DEPARTMENT OF AGING

Ms. **Codispoti**. My name is Connie Codispoti, and I'm from the Ohio Department of Aging.

I want to make a couple of comments. I think that some of you around the table know that Ohio completed a strategic nutrition study just about a year and a half ago, and we looked at a range of issues that look at where the nutrition program has been, where it belongs, where it needs to go in terms of long-term care issues.

One of the statements—and I'll be repeating some of this this afternoon, so you'll have to forgive me, but I can't sit and be quiet—one of the things we identified in that strategic study is that there are so many people who believe in the stereotype of the congregate participant as the well participant, and the home delivery participant as the ill participant. What we found in a telephone survey of nutrition programs across the State of Ohio was that—the average age of our congregate participants was 73 to 75 years of age. So you know there were also much older folks at those sites.

The site managers from Ohio's nutrition programs also estimated for us that 35 percent of those clients could be identified as, indeed, quite frail and needing assistance to get to the congregate site. These clients did not want to become dependent on being at home.

Close to one-third of the congregate clients—I think it was about 30 percent—site managers identified as being not homebound and physically independent but nutritionally dependent upon the congregate program for their only meal of the day.

The other thing I'd like to go back to is to stress a point that goes back to one of the points that Colleen made. In Ohio we also came to realize some things when we looked at just where this country is going in terms of the need for home delivery. Ohio has just gotten into some major State funding in long-term care issues in our last biennial. We used to have a half a million a year in State dollars available for home-delivered meals, and at the beginning of this last biennium that jumped to $5 million across the biennium, so that's a jump from half a million to $2.3 million a year.

As a result Ohio is moving into long-term care programming that is a very coordinated type of program. Some of you here who know about long-term care issues may have read about it.

But anyway, I did some telephone surveying across the country. Ohio was lucky enough that not only did we have the State dollars for use in long-term care, because it's specifically meant to go to home-delivered meals, but we also have a Medicaid waiver program. The way that waiver is set up is that the Medicaid dollars can buy meals. I was curious, about other State's Medicaid Wavier Programs and whether they were also able to purchase meals. One of the things that I found out when I telephoned some other State administrators, was that the way their Medicaid waiver program is set up, is that only if there is a waiting list—I don't know in terms of how long—is the Medicaid waiver program willing to buy the meal. So they were depending on Title III C-2 funds to pick up the increasing numbers of people that they are placing into the waiver programs. They are growing, just like we are.

So I would submit that there's a chance that some of this shift from Title III C-1 and III C-2 has been a natural movement because there just have been greater demands placed on Title III C-2 funds. You're going to see that continue to happen. As I said, my concern obviously for the congregate constituent is that when we are looking at a great number who are now nutritionally dependent on the congregate program, we're not just taking funds away from social clubs.

You'll hear more from me this afternoon.

Ms. O'SHAUGHNESSY. Thank you.

I just want to make one point. You had raised the issue of transportation. Look how Title III is broken up here. You know, 66 percent goes to nutrition and 34 percent goes to supportive services. Well, of that amount that goes to social services, a tremendous amount goes to transportation services; about $67 million in 1989 went to transportation services out of the total amount for supportive services. So I think there is an interplay, obviously, between the supportive services component and nutrition.

I think that June has a comment, and then Janette.

June.

Ms. DURHAM. Several times today we've heard people mention the DRGs. The DRG has affected in my program at home more than one single thing since we've been in business, and we started in 1968. When those DRGs were passed, 6 months from the time they were passed we had doubled the service number.

I think we saved money one place, but it didn't occur to those moneysavers who was going to pick up the tab for that.

Additionally, the paperwork was tremendous on that because those elderly people who previously had stayed in the hospital until they were able to function at home became temporary cases for the program, then they're marked "off"—more paperwork, more casework, all of those things.

So Paul, with your vision, that if we need double money we need to stand up and ask for it, I agree. Let's get the money for our elderly. Let's honor the elderly in our Nation like they're honored in European countries, and let's work. Let's put that vision to work, build our castle in the sky. Those of you in this very room have the ability to put the foundation under those visions.

Was that appropriate?

[Laughter.]

Ms. O'SHAUGHNESSY. Thank you, June.

We have a comment over here. Please identify yourself and your organization.

STATEMENT OF JANETTE MARTIN, MARYLAND STATE OFFICE ON AGING

Ms. JANETTE MARTIN. I am Janette Martin with the Maryland State Office on Aging. That's a pretty hard act to follow, but I do have a few things I would like to say.

One, in support of the recommendations that you all have made, certainly giving some direction to the State Office on Aging—many of us have assumed many of these recommendations, like setting standards. For instance, we have a requirement in Maryland that must offer physical fitness at all of our nutrition sites three times a week. That type of thing would certainly give us more strength.

I would also like to mention that transportation is one of our biggest problems. When you talk about getting people in the rural areas to nutrition sites, we feel that we're lucky to get them there in some instances once a week.

We have done studies, and we know that even coming to a nutrition site once a week seems to benefit them not only from the standpoint of society and the social things, but also from the nutritional standpoint because we are able to get information to them.

Also, I would certainly support the effort, which is not mentioned in the recommendations, the effort to involve the private sector, as Dr. Kerschner mentioned, in our programs. We are involving the private sector, particularly from the standpoint of support for the nutrition programs, but also from the standpoint of getting information out to people about what services are available for the elderly. We have a program called Senior Reach which involves the telephone companies, the Baltimore Gas & Electric Company, and so on. We have about 40 Senior Reach Partners. So that is certainly a help to us, and it is getting information out. That means, of course, that once we get this information out to the public, it then comes back to our local senior information assistance people, to then take care of people better in the community.

I could go on and on, but that's all I'm going to say right now. Thank you.

Ms. O'SHAUGHNESSY. We have time for about one more comment.

STATEMENT OF KAY BISHIRJIAN, GERONTOLOGICAL NUTRITIONIST LEGISLATIVE REPRESENTATIVE

Ms. BISHIRJIAN. My name is Kay Bishirjian, and I am here as the Gerontological Nutritionist legislative representative. But I do work in a Department of Aging in Allegheny County, Pennsylvania.

Yesterday we served 8,000 congregate and home-delivered meals. We called that our Valentine's Day luncheon.

We have done surveys like many others. We find—I go into the centers and talk to the older adults—we find that just a handful eat something before they come to the center. They save their bread, their fruit, their cookies, their milk; anything that they can save to take home, they do take home.

We have also found that that is their main meal, that they rely on that meal. Without that meal we would have many, many more frail elderly. In Allegheny County in Pennsylvania our average age is 73 to 75 years old. They do participate in the program approximately 3 days a week. The majority of these people are widowed and live alone, have very little family members around. They also are very willing to give up their time to volunteer in the program. We have a very intensive sanitation program. We adapt material to fit the need of the volunteer older adult to serve the meal. We discuss portion control. We provide visuals that they can utilize, and have posters made so that they can adapt them. They are willing to volunteer of their time and understand.

Also in our nutritional education that we provide to them, they do care about their health. They do want to feel well. The information we provide to them is beneficial so that they will understand the importance of eating when they are away from the center.

As far as modifications or therapeutic diets are concerned, we serve about 600 or 700 a day. They are geriatric and they are not as tight as they would be for younger people, but one of our concerns is that the special needs for in-home clients—we get requests for renal diets, we get requests for other very severely sodium-reduced diets which we cannot at this time handle. Our concern is that the homebound older adult does need some assistance in the selection of food. This can only be made possible by additional funding so that you can have people in these various areas to continue this type of service.

Also, outreach, outreach workers, the turnover is so great that they'll do a campaign, and by the time they are able to follow up, those individuals are gone. There definitely is a need, but to continue services we do need additional funding to give the staff the stability, that we are here to stay.

I just wanted to share that with you. Thank you very much.

Ms. O'SHAUGHNESSY. Thank you.

I know Connie Benton Wolfe had a comment. I'll ask you to hold that until after lunch, if you don't mind, if you want to be the first commenter after lunch.

We will break now.

[Whereupon, at 11:45 a.m., the workshop recessed, to reconvene at 12:15 the same day.]

AFTERNOON SESSION—12:16 P.M.

Ms. O'SHAUGHNESSY. We have about 25 minutes to have some more interplay in between bites of your sandwich. Connie Benton Wolfe had her hand up earlier before the lunch break, and I'm going to ask her to start off the discussion right now.

Connie, are you ready?

STATEMENT OF CONNIE BENTON WOLFE, EXECUTIVE DIRECTOR, NANASP

Ms. WOLFE. Yes, I am, thank you.

I am Connie Benton Wolfe, Executive Director of NANASP.

The point that I wanted to speak to before we broke for lunch was one related to the fact that as we take a look at being forced into positions where we have to make choices in terms of which of the nutrition services we want to see funding go toward, I think it's important for us not to lose sight of the fact that across the country there is a great interrelatedness of those services. In many of the rural parts of the United States, if there were not meal sites in some of our small towns, there also would not be home-delivered meals in those small towns. The same caterer or central kitchen that prepares those meals and achieves some economies of scale delivers them to the sites, most often; sometimes they are dished up there, and sometimes they come in already prepackaged. Oftentimes the volunteers who deliver the meals are the very same seniors who attend to the meal site. So you have maybe a little younger group of seniors who are participating in what we have been talking about today, as sort of a preventive program, who play a key role in making sure that some of their frailer sisters and brothers, as it were, have access to nutrition, and those occur in a very interrelated manner.

If we emphasize one over the other, I think we have to be careful that we don't in fact lose something that allows the services to continue on.

The other thing that I'd like to say is that in a meeting recently I had someone who has been involved with the programs over a number of years who spoke to me and to a couple of members of our NANASP Board, who asked me if I thought that perhaps congregate nutrition's time had passed. We were very much taken aback because this was a person who had been quite supportive in years past. After leaving that meeting, one of the things I did to kind of reconcile in my mind that that wasn't the case, necessarily, was to go to a meal site.

I would challenge each of us who has an interest in these programs to do that again, if you haven't done it lately.

When you go in and you talk to the seniors who are participating, what you know is that the congregate program in fact is not outdated. It is an important part of their lives. One of the seniors made a relatively succinct comment to me when I started asking some questions. She said, "Home-delivered meals might keep me alive, but the congregate program gives me a reason to live."

I think we can't lose sight of the fact that when we have choices about things like whether we would choose to be isolated and eat our lunch or we would choose to be with a group to eat our lunch, I would probably put before you that each of us, as we went to get our sandwiches downstairs, probably came back in this room and looked for someone that we knew to sit and share that lunch with.

I don't think that we should in fact try and force the seniors, in order to get nutrition into a position of more dependence and isolation than is absolutely necessary.

Ms. O'Shaughnessy. Thank you, Connie. I think that's a good comment about the balance between prevention and long-term care.

Katherine Tallmadge had a comment for us.

STATEMENT OF KATHERINE TALLMADGE, D.C. ADA

Ms. Tallmadge. Thank you very much. I am Katherine Tallmadge, President of the D.C. Area Dietetic Association, and I too have personally administered various senior meal programs in the past.

Speaking to the issue of budget constraints and making the most from the Federal dollar, I would like to remind you of the unique qualifications of the registered dietitian in a multitude of food, nutrition, and management areas.

To become an RD, the Commission on Dietetic Registration provides a national competency examination which tests many of the skills necessary to administer senior programs, skills such as menu planning, cost-containing, program management, personal management, sanitation, as well as nutritional assessment, therapeutic diets, etc. I submit that the RD therefore will save money by, (1) filling a multitude of necessary roles, and (2) by using his or her unique training to get more bang for the buck.

Thank you.

Ms. O'Shaughnessy. Thank you.

I'd like to ask a question. Someone earlier mentioned an issue with respect to employing credentialled dietitians, and you spoke to the issue of registered dietitian. Can you explain the difference between these? Could someone speak to that point?

Ms. TALLMADGE. Will Mary Hess speak to that?

Ms. HESS. Registered dietitians often have many credentials in addition to the registered dietitian credential. The registration credential does cover a number of areas of competency to practice, including the areas that were mentioned. There are many other types of credentials. Certainly, if somebody is licensed in a State to practice, we would certainly agree that that person was credentialed, also. However, many people have related, but not comparable, credentials. They might, for example, have an advanced degree in nutrition; however, requirements for that degree might not include academic content in food service management, program administration, and food purchasing.

The point in support of Katherine's comment is that while there are many credentials available, what this particular credential does is merge the food, nutrition and management aspects, all of which are necessary to assure the competency to provide the multitude of tasks within the program.

Now, this does not mean that there are not individuals who have done this for many years and are not doing a fine job. We are not saying that in any way, shape, or form. However, I do think that we want to call attention to the fact that the uniqueness of our competency-based examination addresses a variety of roles, all of which can be contributory to the program.

As an example I would like to share an experience from a phone call yesterday. I was talking to somebody at the Chicago Department of Aging who told me that as of the present time, they are serving 4,500 congregate meals a day and 3,200 clients get two means a day in the home-delivered meals program, thus serving 10,900 meals a day.

Because of budget cuts, and certainly since the time my firm left the program, they are now at a point in service where they have a registered dietitian who has contracted with them to provide 508 service hours per year. Thus that one person, who is a registered dietitian, has some responsibility in terms of menu checking—not even menu planning—and certainly a minimum amount of time to monitor and assure standards. They have cut out monitoring by professionals. They have cut out training of staff and volunteers by professionals.

So here we have one registered dietitian on an average of 5 days a month, trying to provide professional services for 11,000 meals a day. What we're suggesting is that this level is inappropriately low, and I believe the people, even at the program, would tell you that they have severe reservations in terms of maintaining the quality and integrity of their program in terms of food safety in particular, as well as a great relaxation of standards in terms of monitoring.

There is one other thing I'd like to share with the group. Several people mentioned one-third of RDA. In many years of menu planning and monitoring for that program, I would basically like to agree with what Kay said. I would like you to keep in mind that the one-third is what we consider to be absolute minimum. Until somebody can prove to me—and I daresay this would be difficult to prove—that the people in this program are meeting the other two-thirds somewhere else, I really feel that that one-third is a minimum standard, I am greatly distressed, because of cost and other constraints, by considerations to limit protein and some of the other food components down to lower levels because those would also meet the one-third of the RDA.

The reality is that people are not meeting the two-thirds elsewhere. They are taking that one-third, or hopefully more than one-third, and trying to stretch it to meet a significant portion of their total nutritional needs.

That takes me to the next step. There has been discussion of dietary guidelines in the program. While I am absolutely in favor of the dietary guidelines for Americans and feel this is a very useful educational tool—and this is a personal statement, not on behalf of the association—the first dietary guideline, eating the variety of food and the number of servings from each of those food groups in order to maintain nutritional adequacy, is the number one nutritional concern for the aging population. When we tell people that we would like them to incorporate the dietary guidelines many focus on fat restriction and sodium restriction, because of public concern in those areas, very often the mind leaps to the limiting factors of the dietary guidelines.

If somebody gets 35 percent or 40 percent, or somewhat more than 33 percent, of the calories or fat from a particular meal, I am really not concerned as long as their total for the day does not exceed 100 percent.

In adapting these materials for seniors, I think that we must look at it in that perspective and make sure that the diet is adequate. Once it is adequate, then I am concerned about limitations. But until the point where adequacy is reached, I believe that restrictions should be a secondary concern.

Ms. O'SHAUGHNESSY. Also just to clarify, the law now speaks to the one-third RDA. That is in the law. It has been in the law since the beginning of the program.

We have talked a lot about funding for the program and the inadequacies, from the various persons' points of view, in terms of funding. I see two more hands here; however, I would like Gail Martin to talk very briefly about a grant that she has received from the Administration on Aging, and also working with the private sector. There is this terminology now under the reauthorization of the Older Americans Act, "work on public-private partnerships," and I think Gail's grant is an example of how she has been able to put together some private money with some public money.

So Gail, if you could just briefly go into that, and then we'll go back to the floor for some comments.

Ms. GAIL MARTIN. I'm not the one to talk about public-private partnerships. I think June Durham, who runs an entire program with no Federal or State or local moneys altogether and has a quarter of a million dollar pro-am golf tournament every year and other innovative things, could do a better job of it.

But very briefly, the grant—from what we saw up there in our membership generally, with the waiting lists and problems—this was especially directed to the home-delivered component. If we could alleviate those waiting lists and do it in a very cost-effective way, it might then piggy-back on our members that are congregate and help them as well.

So what we came up with was an idea of putting together maybe a series of 7 days of frozen meals. We looked at shelf-stable meals, and there really isn't much out there that you would want to have every single day. This would be addressed to alleviate waiting lists, to get to the very rural areas—it was thought of originally for the very rural areas; I think John said that not every town has a nutrition program or a congregate program to get the meals out. So it wasn't really thought of to replace what everybody is doing out there and doing well. If you are delivering a hot meal every day and you've got a volunteer to get there, continue doing it. But many programs don't have 7-day-a-week meal service, either.

So it might be just for that 2-day weekend meal, for holidays, for very rural routes, for those who are very tightly assessed who don't need that daily visit every day. We thought of putting together a 7-day frozen meal system, some of which are already in place.

But we took it a step further and we said, "Nobody now is really using commodities." They're not using USDA commodities; 95 percent of the States are taking cash in lieu. Why? Because commodities—USDA hasn't made it easy for us to take those commodities. The paperwork, the amount of bulk that you have to take, you may have to pick it up, it's erratic when it is delivered, and we're not utilizing the commodities. We're taking the cash in place, and hopefully buying American products.

So if we could say to manufacturers that already are using commodities—let's say, for the school lunch program—"take in these commodities," because it's too hard for us individually, little programs, medium programs, and so forth, "put it into this frozen meal, and deduct out the cost of the commodity; full value of whatever you're going to put in there," and there are some very good products in commodities. The quality has come up. We found that out at a focus group. So the better things in truckloads of beef and chicken that no one is using now, you get full value. In the $0.56 that we're getting for commodities as cash in lieu, think about it; you're not getting all that value in food, because by buying a product on the market you are paying a middleman, a broker out of that $0.56 and you're not getting full value.

So if we took the commodities, put them in the frozen meals, maybe we could reduce the cost of the meal and bring it down to—I've looked at some that were $1.67 for a frozen meal.

The third thing was that, okay, we knew we would have some problems as far as some people really needing daily attendance. But that's up to the program to assess who out there could handle a once- or twice-a-week delivery.

Finally, we said that those folks that might be into this shouldn't be messing around, in so many words, with a stove. They really are that frail, or they can't see, they're forgetful. So we worked with a division of Land O'Lakes which is called R-Tech, Results Technology, and it's their R&D arm, research and development. They said, "Maybe we could help you not only with what kinds of menus and so forth that should be put together for this frozen meal system," because they have a lot of RDs and home economists and engineers and scientists and so forth, but we looked at a rethermalization unit and we came up with an idea of a microwave—like a chicken in every pot—a microwave in the homes of those that could utilize them. Because waste management is a big issue today too, and most of us are aluminum and/or clamshells and nobody is doing anything with recycling in any big way in the elderly network, it would be like an airline tray. On the bottom would be a UPC coding—that's owned by Litton, by the way—and the UPC coding, once you put that meal into the over, would read it. The person would merely put it in and shut the door. It would turn it on, set the time, set the temperature, and shut it off automatically, so there would be no burned meals, forgotten meals, and there would be a loud audio and visual signal going with it.

This is just a concept. We don't know if it's good, bad, or indifferent. The first year of the grant is just a feasibility study to say if it is something we should look into.

How would the people pay for that? Well, that's where the private sector comes in. Usually people—let's say companies like IBM; I really don't want to pick on them—they don't give big, amorphous amounts of money to feed old folks. That's just to vague. But we could say to them, "How about purchasing 100 of these units for those most in need in our program?" And it could be Kiwanis, it could be anyone. There is also a means whereby you can lease these. There are a lot of interesting things.

So at this point it is only a concept, and the phone has not stopped ringing. It's been in about seven trade publications. A few of you people here have called us about it.

So that's just progressive thinking. How are we going to handle meals with limited resources? That's it in a nutshell.

Ms. O'SHAUGHNESSY. Thank you, Gail.

I saw a couple of hands raised over here. Yes?

Ms. CHAPMAN. Yes. I just wanted to comment, because it was Society for Nutrition Education that had made the recommendation on the credentialing, and also having the dietary guidelines as one of the standards.

The Society for Nutrition Education joins the American School Food Service Association and other groups in encouraging that the school lunch program be based on the Dietary Guidelines, as well as the current one-third RDAs. With that in mind, too many people believe oftentimes we say that older people—are too old, that with anybody over 55, we can't begin to prevent disease. Research is suggesting that we can intervene at ages over 55 and get a delay of some of the onset of chronic diseases.

So what we're recommending in terms of this is a double standard for the elderly, just like we're using a double standard for children, and that is one-third of the RDA as well as the dietary guidelines. I think it is very possible and doable. Particularly as someone said earlier in talking about the computerized nutritional analysis programs, we can be very creative.

The second issue that I wanted to raise is the issue on credentialing. I would not like to put this on the table for public debate at this point in time because I think there are some merits to ensuring that we have the word "credentialed" well-defined and that we have the elderly programs served by the most competent professionals. People have various different ways of developing their competencies.

What we were meaning by the term "credentialed nutritionist" is an individual who has received training and education from an accredited training or education institution.

So as not to try to "divide and conquer" on this issue, what I would like to suggest is that the Society for Nutrition Education work with the three groups that developed the minimum standards in trying to define this concept with some acceptable language.

So, I think the goal is to have competent professionals being able to deliver the services that are necessary to protect the nutritional well-being of elderly Americans.

Ms. O'SHAUGHNESSY. Okay. Thank you.

A comment over here, yes.

STATEMENT OF AUDREY McCOOL, GERONTOLOGICAL NUTRITIONIST

Dr. McCOOL. I'm Audrey McCool. I am a gerontological nutritionist from Las Vegas.

Just as an overall comment, I think it's very important that we remember that yes, we do need a lot more money, and I think Paul is quite correct; if we don't ask for it, we are never going to get it. But I think we also have to be very proactive in the way that we ask for it. We can't say, okay, we're just going to continue on doing what we've been doing or what we've gradually evolved into doing. I think we have to clearly define in the request that we are serving a range of services which are preventive, all the way through a continuum to various stages of rehabilitative services. I think we have to make it clear, that the nature of our population has changed significantly, as has our sophistication in being able to provide different types of nutrition services. We know a lot more now than we did 20 years ago about what can be done with various types of nutritional support, and I think we have to be fairly straightforward in defining nutritional service support and its potential impact.

I think we also have to remind Congress that yes, we're asking for a lot more dollars, but what we're really asking is for them to consider the return on the investment that they're going to make with these dollars. The bottom line is that it is both cost-effective as well as psychologically desirable to keep people healthy, as healthy as possible, and out of institutional long-term care as long as possible. If this investment is properly done, we can, in fact, provide a very good return on investment for the tax dollar. So, I think we have to ask them from that point of view.

If we're going to do that, then we have to be able to target the use of that tax dollar well, which means we really have to do the things like the assessment procedures the NSI is proposing up front. I think we've used targeting, perhaps, to say, okay, we need to find several groups out there that need service. Maybe we need to redefine "targeting" a little bit more thoroughly and say that we have to target in the sense that we have to know more specifically what our population is, what their needs are, and provide the specific kinds of nutritional services to the people that need those services to make the most effective use of our dollar, and therefore get the best return on the dollar.

If in fact we decide that some of these things aren't Title III C—I hear some discussion about what kind of business we are really in, or what Congress sees that we're really in—maybe Congress needs to also discuss what kind of purpose they really want for this program. If they want it to be all-encompassing, then we're going to have to ask for the dollars. If not, I think they should at least discuss where the other needed dollars are going to come from. Is it a Medicare responsibility to provide in-home tube-feeding service? Because we don't get money for any kind of nutritional services from other sources, whether it's insurance companies, Medicare, or whatever, we need to have a good, solid forum to have people recognize that there is a role for nutrition in health services and that it should be a reimbursable role, whether it's Title III money, Medicare, or whatever.

Ms. O'SHAUGHNESSY. Thank you.

We have time for one more comment.

STATEMENT OF MARILYN MOWER, AREA AGENCY ON AGING

Ms. MOWER. I'm Marilyn Mower. I'm a registered dietitian in Montgomery County, working for the Area Agency on Aging.

I want to take a slightly different tack on this minimum standard one. We've heard from a number of people that this lunch which provides one-third of the RDA minimum is providing more than that in the total nutrition of many of the participants. I want to point to the last part of this standard where it says that "If multiple meals are served each day, the combined meals must provide two-thirds of the RDA for two meals and one-third of the RDA for three meals"—excuse me—"100 percent of the RDA for three meals."

I would like to encourage us to be more flexible than having to provide two-thirds or one-third percent of the RDA for the multiple meals. And I want to remind people that the RDAs for the energy level for these meals are based on recommendations—not RDAs, but recommendations—for adults 51 years and older. We have heard that the average age of participants in our program is over 70. We don't have recommendations for that age group for energy levels. While the RDAs for the vitamins and minerals can be met, when we try to provide enough food to meet the amount of calories that that represents—100 percent—we have a little bit of trouble in getting people to eat that much food. We have seen that, especially in senior assisted housing.

So I think that we need to reevaluate so that we can be more flexible about the energy component of the meals.

Ms. O'SHAUGHNESSY. Does anyone on the panel have a comment back to Marilyn, since this is a very specific comment on the standards?

Dr. Keller, then?

Dr. KELLER. I'm not on the panel, but I did want to talk just very briefly about the RDAs not addressing both sodium content and fat content, I believe, in food. Being a treating physician and having to treat hypertension and congestive failure in so many of my senior patients, I think it is important that we follow guidelines that do address those issues because we are treating people with these diseases. If they are getting their main meal from meals that do not take this into consideration, we have a problem.

Ms. CODISPOTI. Carol?

Ms. O'SHAUGHNESSY. Connie?

Ms. CODISPOTI. This is Connie Codispoti.

I would just like to underscore what you're hearing from so many people. To me, it comes down to the fact that again, as we are getting more sophisticated in our basic medical care and nutritional care of the elderly, we are already beginning to see 20 years later, from when we started this program, that we are not serving a homogenous population throughout this program.

When Ohio put together comments for the American Dietetic Association to bring to the table for the three associations, one of the things we commented on and felt strongly about was that AOA or someone at the national level needed to take some leadership in looking at some research to help us sort through some of these issues. I think that years and years ago when it was one meal a day, 5 days a week in a congregate setting with much of the emphasis on socialization, there was not the need for the emphasis on the populations that we have now. The participants weren't as old as they are now. We didn't know as much back then about nutritional needs and dietary guidelines.

I've had several professors from Ohio State University who are experts in geriatric nutrition who have expressed a grave concern about some local interpretation—in a State other than Ohio—of what the dietary guidelines meant, and how local nutrition programs subsequently changed (to meet Dietary Guidelines) the menus for their senior citizens. The experts had concern about a major change in the amount of Fiber (relative to liquid intake and the potential for impaction and folks who are bedbound) as well as some of the things that Mary has talked about earlier—if we're looking at that one meal a day as the total intake for some of these elderly people who are dependent on the congregate program, then these experts are not so sure that a decrease in protein, a high increase in fiber, and some other recommended changes that we talk about for the geneal health of the general population, are necessarily that desirable for some elderly individuals.

So I think that the overall problem is that we don't have anybody looking at how heterogenous this population is.

Ms. O'SHAUGHNESSY. Thank you, Connie.

I think we're going to need to close this portion of the panel discussion now. I'd like to thank each and every one of the panel, and especially everyone in the audience who has interplayed with the panel, especially on the minimum standards. What I think is very interesting is that there has been a back and forth in terms of discussion of technical aspects of meals being served, as well as delivery issues. Of course, the key of the program is delivery.

At this point I would like to turn the microphone over to Heather, who will take over for the second half of the program.

So thank you, panelists, very much for your participation.

PART II—THE NEED FOR NUTRITION SERVICES—AN OVERVIEW

Ms. BURNESON. Thank you, Carol.

Someone has managed to go unrecognized throughout the morning, and that is Julie Stauss of the ADA who has also been instrumental in helping to develop this program. Although most of you know her, I did want to thank her as well.

We are moving into the second part of the program. It is almost difficult to divide it because we have been talking so much about what we want to see elderly nutritional status achieve. We've talked about nutrition programs under the Older Americans Act. Now, we're going to move to a more general discussion on elderly nutrition. Specifically, we are goint to touch on other avenues that we should be looking at in addition to the Older Americans Act that do address the nutritional needs of the elderly.

We have Connie Codispoti, who is going to provide a "bridge" between our morning and afternoon sessions. We've had numerous conversations, and I'm waiting to see how she is going to condense her ideas into a 10- or 15-minute discussion, because Connie has an awful lot to say.

Following Connie, we will hear from Ed Barron of the Agiculture Committee.

Let me turn it over first to Connie.

Ms. CODISPOTI. Thanks, Heather. I really appreciate the work you have put into this, and I really appreciate being able to be here. I hope you will all bear with me. I'm a little bit under the weather, so I find my voice going in and out. I'm still feeling somewhat shaky, so bear with me.

I thought also that if all of you have had a fairly high carbohydrate lunch and are ready to doze off, we will know that you have not had the power lunch that you needed to have to stay awake this afternoon, but I'll give you permission to fall asleep and I'll leave it to Ed to wake you back up.

When Heather and I talked about what was important to me in the number of years that I have been working in this program—I have been a nutrition administrator at the Department of Aging in Ohio for 9 years; I am also here wearing my ADA Gerontological Nutrition Practice Group hat—but when we talked about what was important to me, I think we agreed that maybe we do need the reminder—about just why nutrition services, and I don't care where the funding comes from, but why those services are so critical to the elderly as a specific population.

We also thought that because of the issues that we've looked at in the State of Ohio, basically as to where this program, Title III and other funded nutrition services, needs to go into the community-based long-term care arena, that I might be a good person to talk about some of the complex issues that are facing us, and I do mean all of us.

My dietitian's mind immediately raced to the statistics and the research that I could quote to all of you today. I am going to quote a few of those because I think they are important.

Mary mentioned one of them earlier today, and that's that there is a study from the early 1980's that tells us that up to 50 percent of the independent-living elderly in this country are thought to have specific nutritional deficiencies. That's a lot, folks. That's half, the independent-living elderly. That's not the institutionalized elderly.

The other statistic that I think is a shocker, just when you think of the scope of the number, is that 85 percent of this Nation's elderly have one or more chronic diseases that benefit from therapeutic nutrition intervention.

When I put those two numbers together, it says to me that we have an aging population that at least some studies have shown are not in great nutritional status. There are more in poor nutritional status, and poor nutritional status is strongly associated with having a depressed immune system. If we haven't learned the importance of an immune system in this last decade, we haven't been paying attention.

So without good nutritional status and with depressed immune systems, it's no wonder that the elderly have a very difficult time in health recovery from colds and flu, in recovery from infections, in recovery from broken hip bones—the immune system is quite important in the repair of fractured bones—and in recovery from surgical procedures, and obviously, bedsores, the nemesis of the long-term care population and those who are bedbound.

So I think it's easy to understand why the elderly are so vulnerable. And there is more current research that struck me when I put together our strategic study.[9] I just heard about it at a conference the year that I was trying to pull this study together. It made it more real to me and more understandable, because the research that was quoted tells us that the elderly have reduced protein stored in their bodies compared to younger adults. As a result, when they face surgery or some other type of physical trauma, their protein stores can be depleted in 3 days. For a younger population, they have a safety window which this study talked about, of about 10 days. So in 3 days, folks, protein stores of the elderly can be depleted and they begin to move into protein-calorie malnutrition, which certainly affects their immune system and their bodies' ability to heal and recover.

Other studies have shown, when we talk about malnutrition, that malnutrition alone has a direct effect on the incidence of medical complications. We all know what effect medical complications have on health care costs.

But I think that to me one of the most significant studies, that tells me that nutrition is important and certainly needs to be considered as a more important factor in health care costs in this country, and especially for the elderly, is the research that concluded that nutritional risk alone—no other variable, but nutritional risk alone—is the most important predictor of the total number of visits by the elderly to physicians, and it alone is the most important predictor for the number of times that the elderly must be hospitalized and must be rehospitalized.

Now, tell me if that isn't significant information that has enormous health care cost implications?

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[9] See appendix, p. 75.

But beyond the research, to talk about why I felt nutrition is important and critical for the elderly today and what some of the complex issues are as we are trying to bridge ourselves out of the specificity of the Older Americans Act and into some of the complex nutrition problems that affect all funding sources, I decided that what was most important was to share a story with you, a true story.

It's a true story about a man that I'll call Mr. Jones. Mr. Jones was a client who was receiving services through Ohio's Medicaid waiver program. For those of you who may not be familiar with it, this is the program in Ohio that works to keep people from premature placement in a nursing home.

Mr. Jones had emphysema, a condition which many of us health professionals refer to as COPD, which means chronic obstructive pulmonary disease, and it is indeed a debilitating disease. Because of his emphysema Mr. Jones, through our Medicaid waiver program, received oxygen every day, to breath. This program also paid for him to receive a canned liquid nutrition product—probably Ensure, as I remember from talking to the dietition—in addition to the one home-delivered meal 5 days a week that he was able to receive from the nutrition program in his town.

One day Mr. Jones' case manager, a very caring and hard-working social worker, came to the dietitian employed at the area agency, and she begged the dietitian to go out and see Mr. Jones in his home because although the social worker thought she knew that Mr. Jones might be getting into some trouble, the waiver program could not afford to pay for both his oxygen and his liquid supplements, and keep him at home.

Susan, the area agency dietitian, who was not funded to visit clients in their homes or perform nutritional assessments or nutrition counseling, knew the social worker was desperate and agreed this one time to go out and see Mr. Jones, because she also knew that there was no nutrition screen or assessment that includes accurate heights and accurate and repeated weights, nor were there any complete dietary intakes done, nor nutrition professional assessments through the Medicaid waiver program. These services weren't funded anywhere in Ohio's network of aging services, not even in the waiver programs.

So Susan knew that if the social worker could see with her eyes that Mr. Jones was indeed beginning to physically fail, then she knew that it had been happening for a while, and it must be serious. So Susan drove out and she saw Mr. Jones, and she performed a quick nutrition assessment and came back to the office, scared for Mr. Jones.

This is hard, because it is real.

For just that one short visit, Susan saw through her professional eyes that Mr. Jones needed more nutritional care if he was not to waste away. He needed more food, more often, and he needed even more liquid supplements. Susan told me later that it absolutely smacked her right between the eyes, when she realized that this state-of-the-art community-based program that we say is giving people a choice to not go into nursing homes, was giving Mr. Jones the best—the very best—it had to give, and it still wasn't enough to keep him from wasting away.

Faced with the choice of institutionalization—and Susan recommended that when she went back and talked to the case manager. She said, "There's no way. We don't have enough to keep him out of here and keep him alive." Faced with the choice of institutionalization, Mr. Jones and his family chose for him to stay at home without adequate nutritional care, and most certainly shortening his life.

Many of us around this table, and most of us are nutrition professionals, know the point I'm going to make next, and I never thought that I had to make such a basic point. But in my 9 years as a nutrition administrator at a State Unit of Aging, I have had to scream from the rooftops the next point that I am going to make. It is so simple, but I have run up against social programs administrators who without nutrition expertise, do not know this point. They simply do not understand it.

The point simply is, that we human beings, without adequate nutritional intake, without adequate nourishment, without adequate food, we do not live. We do not survive. We die. And there is no other community-based service, no homemaker vacuuming rugs, no home health aide bathing, no van driver driving, no Public Health nurse nursing, no social worker case managing, not even a physician doctoring that can do anything for the likes of Mr. Jones when he has, without adequate nourishment, wasted away to the point that all he needs in services is a graveside service.

I think we've lost that point in this program at all levels.

So I think Mr. Jones' true story, Susan and the casemanager, shows us better than all the research statistics in the world just how critical nutrition is to the living and surviving elderly that we are charged to serve.

I also think his story illustrates the complex issues facing all nutrition programs that touch the lives of all elderly. I think some issues are just emerging. Other issues I think we have chosen to ignore, just like the Nation has chosen to ignore the deficit, put it off until tomorrow.

I would submit to all of you here today that we cannot continue to ignore some of these complex issues, because Mr. Jones is everywhere in this country. He is served in every conceivable State, and federally, and locally funded nutrition program that we have. He is in our Title III nutrition programs. He's in our social services block grant programs. He's in our adult day care programs. He's in our senior and shared living housing programs. He's in our adult care homes. He's in our Medicaid waiver programs. He is in our privately funded home-delivered meals programs. He is here today. He is not a client of the future, and we need to recognize that, and that there are complex issues that we have to address before we are going to be able to effectively serve Mr. Jones.

I will mention just a few of them that I have framed as questions. I think they are easy to see from his story.

How can we take the lead together and make sure, across this country, that case managers and social workers and other intake workers are trained by nutrition professionals to be able to early on screen and see some of these signs of nutritional risk?

If that occurs, then how can we take the lead together and make sure that across this country there are qualified nutrition professionals funded to assess and counsel the likes of Mr. Jones when he is clearly at risk?

How can we take the lead together and find ways across this country to help all nutrition programs—I don't care what the funding source is—to find safe and cost-effective ways to serve more than one meal 5 days a week?

How can we take the lead together and find safe, affordable ways to meet the special diet and supplemental needs of clients like Mr. Jones?

How can we take the lead together and find ways across this country to serve the critical nutritional needs of both the short-term recuperating elderly, and the long-term chronically ill elderly? And if you read our nutrition study, we've also found there is research that has shown that there is an intermediate level of client, too, and all have different nutritional needs. But serving all of these clients, if you go back to my first set of statistics, has got to be cost-effective.

Somebody who is coming out of a hospital and needs 3 to 4 weeks of a home-delivered meal while they can develop their support network and keep their immune system up so that they don't start to spiral down and move into protein-calorie malnutrition and more medical complications, serving them has got to be cheaper. I mean, what are we talking about; $8, $10 a day for 3 to 4 weeks? One rehospitalization on a routine medical floor is now what, $10,000? It's probably more. I think that was a figure that I saw a few years ago. If someone is rehospitalized and needs to be rehabilitated and nutritionally built back up with TPN, total parental nutrition, because they need some additional surgical care, those episodes of treatment can cost up to $50,000 an incident.

Now, don't tell me that meals for 3 to 4 weeks aren't cheaper than $10,000 to $50,000 per client.

My last issue is, how can we take the lead together to reaffirm the importance of the congregate feeding program, still crucial to keeping clients like Mr. Jones as functionally and nutritionally independent for as long as possible? Because I will bet you 10 to 1, he was in our congregate program as a more well client; he began to decline, and he continued to stay independent functionally, but he became dependent on the congregate program. He chose then to become dependent on the Medicaid waiver program—above all, to avoid any final dependence on an institution.

If we do pay attention and believe the research and statistics I quoted earlier, and we look at Mr. Jones' story and all of these complex issues, then surely finding some solutions to these issues will be cost-effective in the long run. I personally think that it is way past time for us to come together here today. Who are we? We are lawmakers, we are policymakers, we are program administrators, directors, professionals, community leaders. We are long overdue in sitting down together to discuss these critical issues facing all nutrition programs that touch the lives of the elderly, because I submit to you that if in towns across this Nation the best we have to offer outside of an institution is the choice between the breath of life and the staff of life, then you tell me what choice we've offered Mr. Jones.

I talked to Julie Stauss the other day. She mentioned that up on the Hill there were a number of speakers who were using military analogies. I told Julie that my husband has just been 2 years out of active duty service as a naval officer, but he is still actively involved in the reserves. So the military and the conflict in the Middle East has obviously been on my mind.

So I was thinking about this program and thinking about it somewhat in an analogous situation to where we are in the Middle East. I thought to myself, this Nation did not expect President Bush to do what Congress gave him the power to do in the Middle East without expert military leadership and massive coordination with our allies. And while I don't submit to you that what we do here is the same as what may happen—as bloody as it could be—over there, we've got a Nation, that as far as I'm concerned has a national army of nutrition programs across this country, no matter what the funding source. I think we've fought the good fight every day, but we've been fighting in isolation. And I think we've been hunkered down in our foxholes for over a decade, and we've forgotten that we need to come out and do some intelligence work together to find out who the hell the enemy still is, 20 years later.

I think we know now that the enemy has changed. If we don't know that, then we don't know that they are coming out of hospitals quicker and sicker every day. And the weapons it takes us to fight the good fight for these clients have become much more complicated than they used to be.

I think we need a new battle plan. I think we need a battle plan for the future, and I think it needs to be shaped and molded by the very best experts that we have. I am convinced that we need national elderly nutrition program leadership. We need Federal, State, and local nutrition program experts and nutrition professionals and social program administrators and lawmakers all sitting down together, as we are here today, but they need to sit at the policymaking and decisionmaking table. Without it I don't believe we can begin to shape the plan that these folks need to continue to fight the good fight and make the difference.

For the likes of Mr. Jones, I would like to see us begin this critical work today as we talk about broader issues this afternoon. For I will repeat to you again: if in every town and burg across this country the best we have to offer, outside of an institution is the choice between the breath of life and the staff of life; then what real choice have we given the likes of Mr. Jones?

Thank you.

Ms. BURNESON. Thank you very much, Connie.

You said that the point you made concerning Mr. Jones was basic, but I certainly believe it's the reason we are here today.

The fact that the Senate Aging Committee has come together to work with the Senate Agriculture, Nutrition, and Forestry Committee highlights the importance of elderly nutrition across many facets of the policy arena.

Let me turn it over now to Ed Barron, who is the Deputy Chief Counsel of the Agriculture Committee.

STATEMENT OF EDWARD BARRON, DEPUTY CHIEF COUNSEL, COMMITTEE ON AGRICULTURE, NUTRITION, AND FORESTRY

Mr. **Barron**. Thank you, Heather.

I appreciate this opportunity to talk to you. After Connie's dramatic remarks my comments are probably going to seem a little mundane. I'm hoping that you will take up her offer that this is the year to start; in fact, this is the day to start.

I would like to tell you what the role of the Agriculture Committee might be in the reauthorization. Many of you have probably worked extensively with the Labor Committee and with the Senate Special Committee on Aging on nutrition issues.

In the Senate, the Agriculture Committee has a major role to play with respect to the nutrition of all Americans. For perhaps the first time in history, over one-half of the budget of the U.S. Department of Agriculture is to be spent on nutrition assistance programs. Of course, that in part reflects a substantial reduction in the farm support programs; in part, that reflects a major increase in spending on nutrition programs over the last several years. The Agriculture Committee is and the Agriculture Department handle the whole range of programs, from food stamps to the school lunch program, the school breakfast program, food distribution programs on Indian reservations, the WIC program, the child breakfast program, and many other nutrition programs.

The Agriculture Committee is very pleased to co-sponsor this panel discussion, and I want to focus on some of the recommendations that we heard this morning. Before I do that, there are a few points that I would like to make.

Right now, the food stamp program serves about 21 million Americans. That number has gone up dramatically recently because of the recession. The recession is increasing the unemployment rates and increasing the numbers of persons in poverty. It has led to this dramatic increase in food stamp participation. A year ago, the participation rate was about 18.5 million Americans. Now it's 21 million, and of course, many millions of those participants are the elderly.

Participation in the Emergency Food Assistance Program is also increasing. Approximately 35 percent of the households it serves are headed by an elderly person. The national participation rate in that program ranges from 12 million to 15 million persons.

The commodity supplemental food program, which operates in about 20 States, also serves the elderly.

For elderly persons living on Indian reservations there is the Food Distribution Program on Indian Reservations. And of course, the programs that we're discussing today which are authorized under the Older Americans Act, serve the elderly.

The Agriculture Committee has a somewhat limited role with respect to Older Americans Act programs. We will be working closely with the Labor Committee, and the Special Committee on Aging, on these issues.

I want to bring to your attention a report. Many of you may have seen this already. The information is somewhat dated but it was issued by the Department of Agriculture, written by Mathematica. It contains the final results of the elderly programs study.

There are some interesting points that I want to bring to your attention. This study was issued in 1990, but it relied on data that in some respects are much older.

Point one, the USDA food assistance programs—I've just described them—are only reaching about one-half of the estimated eligible low-income eligibles.

The second point, according to this report, is that 40 percent of the elderly live in low-income households. "Low income" is defined as families whose income is below 185 percent of the poverty line.

The study concludes something that you may already know, that the elderly meals programs are most effective at increasing intake of many important nutrients by the elderly: protein, calcium, iron, niacin, thiamine, Vitamin A, and Vitamin B. These programs are extremely important with respect to helping the elderly meet the minimum daily requirements for those nutrients.

I now want to focus on recommendations that the members of the Agriculture Committee will carefully review.

One of them, of course, is the recommendation to inflation-adjust the reimbursement rate, which is now $0.56. The Committee will look at that carefully. I want to tell you that the new budget rules, which were put in place last year, require "pay as you go." It is my view that those rules would not apply to an inflation adjustment of these programs. The reason is that there is an authorization ceiling, which makes these programs discretionary. The money is obtained through the Appropriations Committee. So these tough requirements with respect to new direct spending programs do not apply. That may seem like a minor point, especially after what Connie said, but in fact it is a major point because of the complex new budget rules.

So that reimbursement rate is an important factor that the Committee will review.

The other thing that we're going to look at is the whole issue of the minimum RDA requirements with respect to the meal programs. Obviously, we welcome your input on that issue. The Agriculture Committee recently required the USDA to issue Dietary Guidelines for Children in the school lunch program. There are dietary requirements right now with respect to the elderly programs, but we want to work with you on seeing whether there should be changes.

Also, the issue of food safety. I have seen some reports that have raised concerns in my mind on the food safety issue. Perhaps more education would be appropriate, but there is a concern about foodborne illness, as raised in some of the papers presented here today. I think we need to focus carefully on that and see if additional steps need to be taken.

Also, I want more information on the NAMP request for broader eligibility with respect to senior meals programs, allowing in additional providers. I would like more information about what types of groups that might attract. I also want to mention that because of an overall cap over the authorization level, with more persons providing meals there might have to be overall reductions in benefits per local program. Now, obviously, if the cap is lifted or if the cap is high enough, then that presents no problem. So I want to explore that further.

In terms of how we would handle this, we will work with the Special Committee on Aging and the Labor Committee about the possibility of holding a joint hearing, or maybe just a hearing of the Agriculture Committee itself on these issues. Of course, the programs expire on September 30, so we need to have our work done by then.

I would like to thank you, Heather, for all your work on this.

Ms. BURNESON. Well, thank you very much, Ed.

I know that there is one other group here that would like to say a few words, and then I would like to open it up to you for some general comments.

In the morning you heard comments from a number of people from the Nutrition Screening Initiative. They have been discussing various aspects of the initiative, but they're now going to give some background on the initiative and what their future plans include. I will now turn this over to Nancy Wellman.

Ms. WELLMAN. Thank you, Heather.

Connie and Ed, I appreciate your call to action, and especially Connie's highlighting not only Mr. Jones' example, but all the Mr. Smiths that are out there, also.

Recognizing some of the needs of these elderly in terms of nutrition was what instigated the founding of the Nutrition Screening Initiative about a year ago. The three partners, the American Dietetic Association, the American Academy of Family Physicians, and the National Council on Aging, felt that although there was a lot of interest in nutrition, often there was more talk than real action. We needed to pull together a coalition of organizations to make something happen. Although the time for nutrition is now, the time for moving it along is going to take a lot of us acting together.

I am now going to give you a brief overview of what has happened in the past year, what's coming up in the near future, and what we expect to see as the long-term results of the Nutrition Screening Initiative in a brief amount of time this afternoon. And some of you may be more familiar with this than others of you. There was a packet available; if you didn't get a chance to pick up a packet on the Nutrition Screening Initiative, please make sure you give us your card and we can get a packet to you after this conference.

As many of you know, this is a multi-faceted 5-year campaign. It has its focus on promoting routine nutrition screening and better nutritional care in America's health care system, throughout the system.

Its initial focus is on the elderly, which is why we're here today, and we have chosen the elderly because we know they are one of the groups that is at most risk of poor nutritional status.

Along with the American Academy of Family Physicians, the American Dietetic Association, and the National Council on Aging, we have about 35 other national health care organizations—volunteer, professional, consumer advocate type organizations. Again, many of you are familiar with a number of those organizations. We are all working together to make sure that nutrition is considered a vital sign of one's health status in this country, just as blood pressure or pulse.

We think we are in tune with the times, and we think that top public policy changes are also going to happen because Healthy People 2000 has as one of its objectives that we increase to at least 75 percent the proportion of primary care providers who provide nutrition assessment and counseling. So we feel, again, that there is a sensitivity to the need for nutrition assessment and nutrition counseling.

This past year we have conducted a survey through Peter Hart Research Associates of the elderly themselves, caregivers, policymakers, and administrators. We have released some of those findings. The media has picked up on a lot of them. Certainly we know through that survey what a lot of you know from anecdotal information, that the majority of the noninstitutionalized elderly Americans do live alone, that they take multiple prescriptions, they often skip meals, they have limited incomes and facilities for meal preparation, and that those, along with other types of factors, make them very seriously at risk for poor nutritional status.

In addition, we have just completed a very extensive review of the date on the prevalence of nutrition-related problems among aging Americans. Many of you know that Dr. Johanna Dwyer was commissioned to do that extensive review of the data. Dr. Dwyer's survey should be part of the record.[10] We believe that within about a week we will be disseminating her lengthy review of the literature. So I think a lot of you will find that very helpful in documenting the need for expanding or strengthening your own programs. We are more than happy to share that review of the literature with you.

The next thing that's coming up very shortly that we're working very hard on is our consensus conference, and we're calling this Nutrition Screening I. It's a consensus conference that's going to be held here in Washington on April 8 through 10. We have about 75 to 100 key individuals from all the organizations involved in the initiative that are going to be getting together to come to consensus on four positions that we are in the process of drafting right now.

We have commissioned four position papers. One is on risk factors of poor nutritional status; the second one is indicators of poor nutritional status; the third one uses those first two to pull together a preliminary draft or design of a screening tool to assess nutritional status; and then the fourth paper will talk very briefly about some promising interventions, because we feel that although the consensus conference won't have an opportunity to figure out what to do with all the poor nutritional status that we're sure to discover, that we need to focus a little bit on what we do next after we find out that it is existing out there in individuals. So there will be a preliminary paper on promising interventions.

So April 8 through 10 will be the consensus conference. We will then be expecting that the organizations that are involved with the Nutrition Screening Initiative will take the positions back to their organizations and pass them or support them or do whatever their organizations are most comfortable with doing in terms of an endorsement, and then we will move into the second significant phase of the Nutrition Screening Initiative, and that is to field-test the screening tool. We will be field-testing the screening tool in a variety of settings.

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[10] See appendix, p. 146.

I want to back up here just a little bit. We know that there are screening tools out there. The difference between what we're trying to develop and some of the screening tools that are in current existence is that the ones that are out there now are fairly discipline-specific. We feel that the better nutrition screening assessment tool will be one that is very comprehensive, that will include not only medical factors or clinical factors, but socioeconomics, independent living ability skills, a variety of factors that all play a role in determining whether one is at risk for poor nutritional status or not.

Then we need to field test that one, refine it a bit, and show that it can help us find those who are most at risk of poor nutritional status, identify them early, do something about them, improve their quality of life, and reduce their institutionalization rate.

In order to do that, once we have the tool field-tested and refined, we then will launch a campaign that will be focused on professional education and development. Again, here I say that we pay more lip service to the importance of nutrition. It's just like with elementary school teachers when we survey them about the importance of teaching good nutrition. They all say, "Yes, it's very important," but they all think somebody else should do it, either because they're not comfortable doing it themselves or they really feel that somebody else's expertise is needed.

So we need a campaign of professional education and development so that we can have a variety of professionals, paraprofessionals, volunteers, and the public at large using the screening assessment tool in various settings.

Simultaneous with all that, one of the main goals of the Nutrition Screening Initiative—I said it was multi-faceted—is that we can't just get people excited about nutrition screening or nutritional status; we have to help change the system through the policy-makers, through reimbursement strategies, and through changing the health care delivery system with some financial realities there. That's why we are here today because again, this is where a lot of that happens. So it is a multi-faceted campaign.

I would ask Gerry and Paul if I've overlooked anything, to fill the group in on the details.

Paul.

Mr. **Kerschner**. A couple of things. One is something that was said earlier down at the end of the table there.

My favorite line is that "data is not the plural of anecdote," with all due respect to our former President. [Laughter.]

One of the things that the Nutrition Screening Initiative is trying to do is to collect good, hard data that tells us something about the elderly. You take that data and then you turn that into an instrument, and you use that instrument to intervene and to do some good. We are basing this whole initiative on, hopefully, timely and accurate data that can then be translated into practice.

Also, we see the nutrition screen as being relatively inexpensive and taking place in a variety of settings—not just in medical offices, although that's important, whether it be in a physician's office or not; it can take place in a hospital, it can take place in a nursing home, in an adult day care center, a senior center, a retirement housing project, a public housing project, in a variety of places where older people congregate and can be picked up and screened and triaged. A lot of the settings where you all work and where all of us who are in the aging field have colleagues that work in the health service and health care arena, they can triage these people and do appropriate services once they are screened, whether that be into some medical interventions, whether that be different fields, whether something else is picked up and they need other kinds of social services, legal services, what have you.

So we see this as having broader implications for all of us who are working in the aging field. Looking at the elderly, we don't think that age per se is the important factor, although obviously for the old-old—again, we're talking mostly about women; for older people of color, nutrition is a critical issue—but eventually we want the screen to be based on people's functioning ability rather than their number of birthdays. But we're starting out, anyway, looking at the elderly.

I will turn it over to my colleague on my far right.

Dr. **Keller**. Well, as you can tell from my gray hair, I have grown old gracefully with my patients. I have a very large geriatric practice. Probably 35 percent of my patients are over 60 or 65, and the group of five physicians I am with probably has about 250 nursing home patients. So nutrition has been a very important aspect of our practice, as it is with all family physicians, I think. We look upon nutrition as a very definite vital sign, just as we look upon a person's blood pressure and temp and weight and height. Nutrition is also a vital sign of their health status.

Screening has been important to me because it sort of focuses attention, both that of the patient and the physician as well as other allied health personnel, as to what is important and the importance of it. If you actually ask questions to a patient or screen the patient, the patient then becomes more aware of it and says, "Hey, this must be something pretty important if somebody is going to ask me about it." If we can convince our people in our offices to ask questions regarding that, then our own personnel are more apt to talk about good nutritional practices with our patients.

So I think screening not only picks up these people long before they get to Mr. Jones' point, and I assure you that I have several Mr. Joneses in my own practice, but we want to get to these people long before they get to that actual situation.

I certainly agree with you that the large number of nursing home patients that I see, many of them could actually be maintained at home if there was adequate care at home, and they wouldn't be paying that $1,200 to $1,300 bill to the nursing home. They could get along much cheaper paying $200 a month for meals, or less, and then some other support people.

I also have a story about the benefits of nutrition. My tennis partner, who is even older than I am—he is in his late sixties—just underwent bypass surgery. Despite the fact that he's in excellent condition and really follows excellent nutrition guidelines, he did have bypass surgery. He left the hospital in 5 days. I saw him yesterday before I left, some 10 days after his surgery, and he is outside walking around his yard. This man survived surgery as if he were 50 years of age, and mostly because he was in great shape, and good nutritional status certainly played a very important part in his recovery.

I can tell you, my patients who have pneumonia and other infections, who fall down and break their hips—if I have an aged patient who breaks her hip and she's in poor nutritional status, I forget the statistics, but it's very high. She'll be dead within—30 or 40 percent are dead within a year afterwards because they don't do well after surgery if they're in poor nutritional health.

So I think it's just very, very important to maintain good nutrition.

The reimbursement issue is a very, very big part of the issue; not just reimbursement, but moneys for research. There has been such little work done in nutrition research, as far as I am concerned. Second, if we're going to evaluate, if we're going to ask physicians to take time in their offices to do nutritional counseling, if we're going to consult dietitians—and I do have a dietitian in my office twice a week that I can send my patients to, and many times I am personally absorbing that cost because I cannot have them reimbursed for those services—but if we expect people to render these services, we've got to face the issue of reimbursing for nutrition counseling, as well as the whole aspect of prevention care. Prevention is important. We've got to make people realize that prevention saves money in the long run and that it's worth that investment.

Ms. **Wellman**. In closing I would like to offer this call to action. I don't want you to feel that we are going to fix everything and that we don't need any support. We are here because we need your support.

The main things in which we need your support are not only in participating in the Nutrition Screening Initiative right now, but helping us as we advocate for more emphasis on nutrition funding of things like the documentation of the extent of malnutrition in population groups in this country—is it 15 percent or is it 75 percent among the hospitalized or the institutionalized? It's a pretty big range. We don't know.

What about research on the prevention aspects of nutrition? How can we successfully know how we're doing our job well without documenting the effectiveness of the nutrition screening tool in a preventive mode?

So we are here to talk to you and ask for your support so that we can nudge the funding situation here in Washington, that more research activities can be focused on nutrition.

Ms. **Burneson**. Thank you all very much. It sounds like quite an ambitious program that you've set out for yourselves but an important one, because we've all spent the day today talking about elderly nutrition and we don't even have data that we can all agree upon.

I would like to thank, Ed, Connie, and the nutrition screening initiative representatives for their comments. I would like to open it up to anyone who has questions, or comments on what has been said.

Ms. **Porter**. I'm Donna Porter from the Congressional Research Service, and I've enjoyed very much hearing people's comments here today, especially because it gives lots of ideas for things that we're going to have to address here on the Hill in the coming year.

As I help Congress think through these things, some thoughts have come to mind. I bring them up maybe not so much as points of discussion but rather as something to keep in mind as we address many of the issues raised here today. I am going to make four points. They are separate, but at the same time interrelated. I'm not sure which one comes first, because this is kind of a "chicken and egg" thing.

The first question I'd love to see answered in relationship to the discussion on one-third of the RDA for the elderly is trying to determine whether that number is even appropriate any longer. I'm not sure it's appropriate in the school lunch program, but I think we need to think about it. If in fact people are eating half of what they consume a day in these programs, then maybe that is what we should be addressing. We don't have that kind of data. So I think that we have to get some handle on that.

Now, some of that may come out of the kinds of things that the Nutrition Screening Initiative is going to address, but the second point I would like to address is that I think now that we have mandated that this country have a nutrition monitoring system, one of the groups that should be of focus on a regular basis, maybe not every year, but should be examined frequently, is the elderly. They are not singled out by the Hanes Study nor by the USDA nationwide food consumption study at this point as a separate group from other adults, to the extent that we are concerned about them here.

That brings me to my third point. Once we know how people eat, what they're eating, in what setting, and what their overall nutritional status is, should we have a set of dietary guidelines for the elderly? They're not like the rest of the population. We have already determined within the school lunch population that they're somewhat different. Maybe we need to think about their special needs. Maybe they need more calories. They certainly don't need the sodium like the rest of the population may be consuming. So there may be some need to fine-tune that for the elderly.

The fourth point I would bring up in relationship to our mythical but very real Mr. Jones is whether we need to think about rebates for various nutritional supplement products for this group of people, just like we have in the WIC program for the infant formulas.

Ms. BURNESON. Thank you.

Are there any other questions? Yes?

STATEMENT OF DOROTHY HUMM, VISITING NURSE SERVICE, ROCHESTER, NY

Ms. HUMM. I am Dorothy Humm. I work for the Visiting Nurse Service of Rochester, NY, for their 33-year-old home-delivered meals program as the manager of that program, and I also consult with our waivered Medicare long-term home health care program. Just so that you know where I'm coming from, I'm a registered dietitian, an active member of NAMP and ADA, and I have lots more credentials in the management, nutrition, and health areas.

So I'd love to say a lot of things, but I've learned that I can't always do that. So I'm simply doing to be focusing on the funding needed to provide the minimal nutrition needed by our elders.

First, the full allocation appropriated should be provided to the nutrition programs without transfer.

Second, I believe we should require that administrative registered dietitian professionals should be at national, State, and local levels to get the more cost-efficient managers at those levels.

Thirdly, we also need to look at the public-private partnerships to raise funds to supplement the Federal funding. We happen to be part of the Meals-On-Wheels American program as well.

But I think also we should look to an idea of how we can keep the excess moneys raised. This past year I was in a strange situation. I raised too much money. I budgeted the $0.90 average participant contribution. I received a $1.30 average. What that meant was that I could not spend all of my Title III C moneys. I could not bank the contributions made by those participants, specificially for that program. I lost that money, obviously, and it was in five figures. If I have a year, this year like I has in 1989 where I overspent my budget because I served too many meals, I don't have that extra money.

I think we need to look at creative ways of funding. We clearly need more funding. I don't think there's any question, but how do we do it? Do we keep it where it has been allocated? Do we bring it in from the outside? Or maybe we do that and more.

Thank you.

Ms. Burneson. Thank you.

Are there any other comments?

STATEMENT OF ELAINE PREWITT, UNIVERSITY OF ILLINOIS

Ms. Prewitt. I am Elaine Prewitt. I am from the University of Illinois at Chicago.

Just in listening to all the comments this afternoon, I want to reiterate a couple of other points that have come to mind as I listened.

I would like for us to think about the possibility that at some point someone may ask to document what impact this program is having. I say that because of the point that has come out a lot today, because of budget constraints and this kind of thing. So at some point someone might ask, "Yes, you're serving X number of people, but are those people in fact consuming those meals?" We know they are, but policymakers need data. They need hard information. That information can come from subjective reports, interviews, looking at the amount of food that is thrown away, or whatever, but I would propose that we keep that in the back of our minds, that at some point someone might ask how we know that.

Of course, we have data in the literature that documents dietary intake and that substantiates the fact that this program makes a substantial contribution to the total daily intake of persons. We wouldn't argue with that, but I would say that we must keep in the back of our minds that the evaluative process needs to be ongoing to some degree to document that, yes, we are doing what we're doing, getting the maximum for what we're supposed to be doing, and we need more to do it better.

Ms. BURNESON. Thank you. I certainly agree with that. We need some reliable data. This is especially important during this year of reauthorization. Thank you for that comment.

Carol.

Ms. O'SHAUGHNESSY. Yes. Someone brought up the issue of program contributions. I think it is interesting to note what the program contribution rate is under the nutrition program.

In 1989, which is the last year that we have figures for program contributions, about $180 million was raised from voluntary contributions on the part of participants, and 55 percent of that amount came directly from the congregate program.

Ms. BURNESON. Thank you.

Are there any other comments or questions as we conclude this session? Yes?

Ms. JANETTE MARTIN. Janette Martin from Maryland.

I was interested in the comment from the Department of Agriculture group, the fact that over half the people who are entitled to food stamps, as I remember, were utilizing the stamps. I find the utilization of food stamps in Maryland extremely difficult since there is a 14-page form that must be filled out for each individual. It used to be 17 pages, so I guess that perhaps by complaining I have had some effect.

Mr. BARRON. South Dakota's was 41 pages a few years ago. [Laughter.]

Ms. JANETTE MARTIN. It seems horrendous, even for me—I happen to be fairly qualified to fill out the form—and it would seem that this is one way of addressing some of the malnutrition in our Nation. Those forms ought to be seriously looked at.

Mr. BARRON. Let me address that for a second.

The Department issues a type of guideline application form, if you will, but the States really have a lot of leeway in designing their own form. That was part of the problem with respect to South Dakota.

Some States, though, have done an excellent job. I think Indiana has a one- or two-page application form for the food stamp program. So States do have a lot of flexibility, and I think the Department is willing to work with them to help design forms that are as short as possible.

That is, indeed, one problem with respect to food stamps, and there are many others, as you know. There is sort of a stigma associated with the use of food stamps, and that does seem to be a problem among the elderly in particular. The elderly with disabilities obviously have a problem just getting the food or getting the food stamps. So there are a number of problems associated with that.

Ms. JANETTE MARTIN. Before I destroy my relationship with the food stamp people, they have made it possible for some people to obtain their food stamps by mail or by having a representative go pick up their stamps.

But the answer that they give me is, "Well, we are just meeting Federal regulations."

So we will keep trying.

STATEMENT OF LARRY WHITE, AARP

Mr. **White**. My name is Larry White, with the American Association of Retired Persons.

I would like to make a comment about your last statement. We did work last year with Ed Barron and, I am pleased to say, the Aging Committee, Mr. Pryor's staff, and a number of people around the room on the food stamp issue because AARP has prioritized low-income seniors in our policy for the last 2 years, and we expect to continue this initiative. Not only were we concerned about the fact that many older persons who otherwise would qualify for food stamps were not receiving them, but it is somewhat mistaken to assume that the vast majority of them who do not receive food stamps do so because they are afraid. Many of them don't know how to apply or they are intimidated by the process that you mentioned.

A third important factor is what is called the minimum benefit, which is only $10 and hasn't changed since approximately 1977. That minimum, for which many seniors only qualify—and there are lots of reasons; we have attempted to work with both the House and Senate Agriculture Committees on making some adjustment, or at least adjusting that to inflation, and we've had some limited successes. These include some novel ideas that we would still like to work with them on regarding how resources and assets, especially money, are counted toward food stamp benefits. And that is a critical area of the food stamp program. The nutrition program for low-income populations is the most important component, and I don't think we can afford to overlook in any of our strategies how that can play into whatever policy agenda we set for feeding and ensuring the high nutritional standards for older persons.

Thank you.

Ms. **Burneson**. Thank you.

Mr. **Barron**. I was going to say, those are very good points. People forget that the budget for the food stamp program is $15 billion or $16 billion per year. It's an enormous feeding program. We have tried over the last few years to make improvements and to make it easier for the elderly to participate, but the participation rates are lower than they should be. Some of the factors that Larry has just pointed out, I completely agree with; they are impediments to participation. We were able to do a little bit with that $10 minimum allotment, but not what they wanted. Part of the problem we had was a budget problem, to be blunt. We ended up inflation-adjusting that $10 minimum benefit, but we had to round to the nearest $5. By doing it that way, it cost zero over the next 5 years, so we are able to pay for it by not taking it away from some other program. But that's an example of what you have to do sometimes because of budget constraints.

Mr. **White**. I would like to say, to the efforts of Ed Barron and John Monahan along with their House counterparts, that one improvement that we did see in the minimum allotment was the provision that allows individuals who do receive the minimum benefit, especially if you're in a rural area—and we'd like to look at some of these issues as we discuss reauthorization transportation issues—that if you only qualify for the minimum benefit in food stamps, it's not really worth it to make that trip to the food stamp office if you have to pay somebody $10 just to get there. So now the law will permit individuals who receive the minimum benefit to get that benefit in payments up to three months at at time.

Ms. **Burneson**. Thank you.

Are there any other comments?

Ms. **Codispoti**. I've got something that is related to research that struck me when Donna spoke earlier. I'm back on long-term care issues again.

We talked a little bit about this in our strategic study. I would like to see some studies done, if at all possible, to look at the relationship between functional assessment and nutritional assessment or nutritional risk. One of the things that we began to realize when we were putting the strategic study together as nutrition professionals was that long-term care administrators, in their efforts to find a way to prioritize long-term care clients for eligibility, were using functional assessments and ranking or looking at the number of IADL's or ADL's—and I'm not sure how many people here are really familiar with that, but they are activities of daily living, which is ADL's, and IADL's are independent activities of daily living, which is like a step up from activities of daily living.

We realize there is a tendency to put together prioritization systems that say that if someone is impaired in two or more IADL's or ADL's—they usually start at that level—they are in greater need of community-based, long-term-care programs. The concerns that we found as nutrition professionals were that we think there is some mislogic there in assuming that all activities of daily living, if you are impaired in those, that there is equal outcome for the client. Some of those ADL's can be dressing one's self, feeding one's self, toileting, and there are several others. Obviously, if you can't button a blouse, you are impaired in dressing yourself. But if you do not have assistance in that, you don't quite have the same outcome as if you cannot feed yourself and cannot get assistance.

I want to go on record as saying this because we've had some local programs, in their efforts to try to prioritize clients, who were setting criteria, using Title III C–2 money and trying to do a care coordination program using Title III C–2 money, pooled in with Title III B money, and they were choosing to set criteria for that Title III C–2 money that said that you had to have two or more impairments, and you had to need the service for 3 months or longer. There was no other C–2 money allowed to those providers in that planning and service area.

So I think, again, if nutrition professionals are not involved in looking at how some of these policies and program administrative policies get set, there just isn't realization on the part of the folks who look at those in very well-meaning ways—and they need to do that; the money is tight and we have to look at prioritization—I don't think they really realize what potential effect on the clients is, and they are not the same.

We were just praying that we could find some study somewhere that would say that if you were impaired in two or more ADL's, there was research that would show that you were probably at high risk for nutritional impairment as well, but we haven't seen anything. We would love to see something like that. I can't imagine that there isn't some relationship.

I'll just end it there.

Ms. **Burneson**. Thank you very much, Connie.

Carol, did you have something?

Ms. **O'Shaughnessy**. Connie, the National Medical Expenditure Survey has done some work on looking at the community-based long-term care population, grouping them by ADL and IADL, on walking limitations, and there is some information in terms of use of community services. They do specifically look at home-delivered meals. That might be something you might want to look at.

Ms. **Codispoti**. We were also hoping we might have a bit of State money left over to fund a particular project that was going to try to track some home-delivered meals clients compared to those who did not receive home-delivered meals. But I think that's real difficult, and complicated to try to follow folks to see whether they do end up having complications, if we're talking about the short-term ones, the acute recuperative type of client. We were looking for that type of study. I would really love for someone to take an interest at the national level in that type of study, because I think it is a more complicated form of research to figure out how you can easily follow what happens to people and begin to document just what the differences are.

I think in the long run it would be good information for us to have one way or the other.

Ms. **Burneson**. Thank you very much, Connie.

Julie, did you have something?

Ms. **Stauss**. I thought I could maybe say something today.

Seriously, I'm really pleased that the Aging Committee has decided to look at nutrition. I think it's a first step in all the activities that all of us have talked about today. We need to work together and we need to look at it more broadly. So I appreciate your hard work. I know how hard you have worked, and the hard work of other people on the committee. I appreciate the opportunity to bring dietitians from at least the eastern part of the country in for today's meeting, and for your asking for their input.

Last of all, I have asked the dietitians, or some of them, to stay for a little while after today's roundtable so that if you have more questions or if they can help you further in any way, we're going to be around for a little while.

Ms. **Burneson**. Thank you very much.

I thank all of you. I know that many of you have traveled a great distance to be here today. The success of this meeting depended on you. I feel that it went quite well, so thank you, everyone, for coming. We hope this opens channels of communication with the Aging Committee, and with the Senate Agriculture Committee as well. Use those channels and keep us educated on nutrition.

Thank you.

[Whereupon, at 2 p.m., the workshop was adjourned.]

APPENDIX

Item 1

MINIMUM STANDARDS
for the
OLDER AMERICANS ACT NUTRITION PROGRAMS

PRESENTED

to the

UNITED STATES SENATE
SPECIAL COMMITTEE ON AGING

and the

COMMITTEE ON AGRICULTURE, NUTRITION AND FORESTRY

by

THE AMERICAN DIETETIC ASSOCIATION

NATIONAL ASSOCIATION OF NUTRITION AND AGING SERVICE PROVIDERS

NATIONAL ASSOCIATION OF MEAL PROGRAMS

MINIMUM STANDARDS FOR OAA NUTRITION PROGRAMS

The American Dietetic Association, the National Association of Meal Programs, and the National Association of Nutrition and Aging Services Programs strongly recommend that the following standards be incorporated into the Older Americans Act. As service providers responsible for program implementation, we believe these minimum standards must be established at the Federal level. The weight of law helps assure that the largest number of high quality, nutritionally adequate meals will be served under safe and sanitary conditions at the lowest possible cost. Our continued interest in meeting the nutritional needs of older Americans will reduce the end costs of health care as well as improve quality of life. Adequate funding should be provided in all cases to accomplish these minimum standards, so that no loss of meal service to older citizens occurs.

1. **Meals shall incorporate the U.S. Dietary Guidelines and meet a five day time-averaged intake of one-third of the daily Recommended Dietary Allowances (RDAs) as established by the Food and Nutrition Board of the National Academy of Sciences, National Research Council. If multiple meals are served each day, the combined meals must meet 2/3 RDA for two meals and 100% RDA for three meals.**

Comments. The application of the Recommended Dietary Allowances is based on: "Underlying all uses of the RDAs is the recognition that humans are highly adaptable. Throughout its existence the human species has developed regulatory and storage mechanisms that permit it to survive in a variety of environments and to withstand periods of deprivation. These basic biological considerations, coupled with the fact that the RDAs include reasonable margins of safety, are the overriding considerations that should guide the user in applying the RDAs in specific situations. Experience with uses and misuses of the RDAs has indicated that certain areas require emphasis and clarification. ....the terms *per day* and *daily* should be interpreted as average intake over time..... For most nutrients, RDAs are intended to be intakes over at least 3 days; for others, (e.g. vitamins A and B12), they may be averaged over several months." Recommended Dietary Allowances, 10th Edition, National Academy Press Washington, D.C. 1989, p. 20.

Menus should be planned to take into consideration ethnic, cultural, and regional preferences especially as expressed by each nutrition project's Senior Nutrition Advisory Council.

2. **Nutrition education shall be provided on a quarterly basis to all participants in the C-1 and C-2 meal programs.**

   Comments. Nutrition education is the process by which individuals gain the understanding, skills, and motivation necessary to promote and protect their nutritional well-being through their food choices. The materials provided must be accurate and appropriate to the audience and provided by registered dietitians and/or staff who receive guidance from a registered dietitian.

3. **State Units on Aging must develop training guidelines to assist Area Agencies on Aging and nutrition program providers in developing and implementing appropriate regular and ongoing training of all aging network nutrition program employees and volunteers.**

   Comments. Professional staff and volunteers need to be actively engaged in ongoing training to ensure the most effective management of a nutrition project. Areas of critical importance for development include, but are not limited to; management of food service operations (catered or central kitchens); effective use of USDA commodities and other donated foods; food safety and sanitation; community resource development; purchasing for cost control; the role of nutrition in long term care; and associated nutrition and health issues.

4. **State Units on Aging must develop minimum assessment criteria for the determination of participation in the Title III-C-2 program. The criteria developed must include a reevaluation period to determine the need for continued participation by clients and should take into consideration the participant's need for other services.**

   Comments. In order for homebound older persons to remain independent and in their own homes as long as possible, their eligibility for home-delivered meals and other appropriate services must be assessed. The assessment should focus on a variety of factors including but not limited to: target population of frail elderly poor, minority poor, functional level of mobility, physical and mental disabilities, general health, nutritional need, family support, isolation, homebound, lack of transportation, etc. The home delivered meal is often the entry point for other needed services.

   The purpose of reevaluation is to evaluate the participant's general and nutritional well-being and to determine the whether the need for home-delivered meals still exists.

5. **The minimum assessment criteria shall also be used to identify participants at risk for the purpose of making referrals to appropriate social service agencies and to qualified nutrition personnel.**

   Comments. Determining a participant's medical and social needs and the need for nutritional assessment and counseling will help identify what additional nutritional and social services the older person must have to maintain or improve their nutritional status, health, and well-being. Currently, funding for these services is inadequate.

6. **A minimum of one full-time registered dietitian shall be employed by the AoA (at the central office and at each regional office) and by each state unit on aging with administrative duties for the nutrition program that include 1) nutrition program design, implementation and evaluation, with emphasis on service cost containment, service safety, and service quality and 2) research and development with emphasis on service integration with community based programs, including the development of special nutrition services for special-needs populations and on defining the long range role for the nutrition services in community based care systems.**

   Comments. There is a need for nutrition expertise in program administration, cost control budget negotiation and service systems planning, and in leadership roles in identifying the long range issues and solutions of the nutrition programs.

   Regional nutritionists should be available for technical assistance to State programs and have the budget to travel to program locations, training conferences and state meetings within their region to be fully effective in performing their responsibilities.

7. **Nutrition providers must conform to the U. S. Public Health Service Code and additional State or local laws regarding the safe and sanitary handling of food, equipment and supplies used in the storage, preparation, service and delivery of meals to an older person. Each state shall set maximum delivery times and temperature requirements for hot, cold, and frozen meals.**

   Comments. The elderly are particularly at risk when foodborne illness is contracted, and food that is marginally safe for consumption can seriously threaten their lives. Microbial contamination is a top priority safety issue related to food. Meal service from production through delivery has the potential to become a public health hazard, especially for the frail and debilitated. As this service is repeated, the greater the chances that human error, contamination and the elements of time and temperature will combine to create a major foodborne illness incident. These services must be done correctly to prevent harm to the participant.

Item 2

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AMERICAN DIETETIC ASSOCIATION
RECOMMENDATIONS
for the
1991 REAUTHORIZATION OF THE OLDER AMERICANS ACT

February 1991

The American Dietetic Association has over 60,000 members who promote optimal health and nutritional status of the public through the provision of direction and leadership for quality dietetic practice, education, and research. The older adult population is an area of concern to our members.

The Older Americans Act of 1965 made possible community-based services and programs that assist older adults in maintaining independence and dignity, social relationships, access to community services, and other available opportunities for interaction that enrich the daily lives of older adults and delay the onset of frail, dependent conditions.

The congregate and home-delivered meal programs are probably the most visible and recognized service of the Act. There is an increasing demand for nutrition services of the OAA. ADA believes that Congress should act to give the OAA the support that it needs to meet this demand and has the following recommendations for consideration during the reauthorization of the Act:

QUALITY ASSURANCE

The employment of a Registered Dietitian at the federal, regional, state, and provider level could assure a quality level of nutrition service by:

1. the development and monitoring of nutrition service standards;
2. providing technical assistance and training for program staff regarding such areas as nutrition education, sanitation, cost-control, menu developement, therapeutic menus, and the nutritional assessment of the elderly;
3. providing nutrition expertise in program administration;
4. the development of model nutrition programs designed to meet the changing population of elderly.

NUTRITION PROGRAM STANDARDS

Minimum standards for the Elderly Nutrition Program should be developed to assure that the largest number of nutritionally adequate meals will be served under safe and sanitary conditions at the lowest possible cost.

The present standard of one-third the RDA for a meal should be retained with some modifications. Additional standards should be developed to address such areas as nutrition education, safety and sanitation, in-service training, assessment criteria, staffing, and nutritional analysis.

Research needs to be done to produce dietary recommendations specifically for older Americans. Recommendations should not only be developed for the well elderly but also for the frail and sick. New research regarding fat, sodium and fiber, as applied to the elderly population, should be considered when developing these recommendations. The same research base could then be used to create RDAs appropriate to older populations. Subsequently, OAA standards should be modified to reflect the revised RDAs.

RESOURCES

TRANSFER OF FUNDS BETWEEN PROGRAMS

The Older Americans Act currently allows for a 30% transfer of funds between the congregate meals, home-delivered meals, and support services. In the past few years there has been an increase in the transfer of funds from the congregate meals to the other categories, home-delivered meals and supportive services. These net transfers decreased the congregate allotment by 16.5% in Fiscal Year 1989.

The intent of the OAA nutrition program is to address the nutritional needs of both congregate participants and the home-bound elderly. However, due to inflationary increases and the transfer of congregate funding to other services, the congregate meal program is eroding.

Transfer of funding should be allowed only within nutrition services. Funding should be increased proportionately to meet the growing need for the supportive services and the congregate and home-delivered meal programs.

USDA PER MEAL CASH/COMMODITY ENTITLEMENT

USDA cash/commodity entitlement has had a fixed reimbursement rate for over the last four years of the 1987 reauthorization. The reimbursement rate per meal should be adjusted annually to include inflationary costs.

TARGETING

Targeting and outreach to certain subgroups of older persons, particularly low-income, minority, rural, or frail persons, should be emphasized during the reauthorization.

The number of minority participants has declined 27 percent since 1981. Although a number of provisions were made during the 1987 reauthorization, the emphasis of this targeted population would be strengthened if the Federal formula allotment to the states would include the targeted population factors.

HEALTH PROMOTION

ADA urges Congress to authorize adequate funds to continue Part F of the Older Americans Act - Preventive Health Services. Section 316(a) of the Act authorizes health promotion activities that cover routine health screenings, exercise programs, home injury control programs, nutritional counseling and educational services, mental health services and other educational and counseling services. Prevention is one of the most neglected areas of our nation's health care system. Presently, health care delivery is directed at disease treatment, rather than at risk reduction, disease prevention or health promotion. The opportunity to reduce risk, and thus lessen the need for institutionalized care, and to improve the independence of older Americans should be our goal.

DIVERSIFICATION OF SERVICES

DEVELOPMENT OF NEW PROGRAMS

Nutrition programs and other supportive services need to adapt to a changing aging environment. With the increasing number of frail elderly, the need for in-home services such as home-delivered meals also increases. The development of community based care programs which include a registered dietitian to assess the nutritional status of homebound elderly is necessary for the prevention of malnutrition among this population. Also, the provision of therapeutic diets and supplemental nutrition is needed to meet the needs of those who are identified to be at risk.

Nutrition intervention, including nutritional assessment and counseling, is critical for the frail, home-bound elderly. Early intervention can improve current problems and prevent additional problems that often lead to admission to a long term care facility

The congregate meal program remains a viable program for delivery of services to the free-living elderly population. It not only provides a nutritious meal in a social setting but creates an opportunity for activities such as health promotion, health screening, caregiver training, mental health counseling, financial management, legal assistance, and benefits counseling. These activities may delay the need for more extensive and expensive in-home services later.

DEVELOPMENT OF PUBLIC/PRIVATE PARTNERSHIPS

The aging network needs to concentrate on the development of programs that strengthen cooperative arrangements with private industry, the community, and other institutions. These partnerships should be encouraged in the reauthorization.

DATA COLLECTION

Program reporting requirements should be standardized among the states. Standardized taxonomy and methodology of reporting should be used by the states, area agencies, and service providers. Little information is being collected to determine unmet service needs. Information on service utilization, activities and the kinds of services provided, the impact of the nutrition programs on the participants, and the level of unmet need is crucial in planning for present and future services.

COMMISSIONER ON AGING

ADA supports the elevation of the position of Commissioner on Aging of the Administration on Aging (AoA) to Assistant Secretary status within the Department of Health and Human Services. This would enhance the ability of AoA to coordinate the various levels of service provided by the different agencies within the Department and provide better control over program administration, operations, and budget.

SUMMARY

Nutritional well-being is an integral component of the health, independence, and quality of life. Research, as well as participant comments, support this. Through the reauthorization of the Older Americans Act, Congress can express its continuing support for the optimal health and wellness of the aging population of our society.

ADA is available as a resource. Please contact Julie Stauss, RD, in the Washington office at 202-371-0500.

Item 3

NANASP

NATIONAL ASSOCIATION OF NUTRITION and AGING SERVICES PROGRAMS

United States Senate

Special Committee on Aging

Older Americans Act Nutrition Policy Forum

February 15, 1991

Nutrition, as championed through the Title III congregate and home-delivered meals programs, has long been a significant component of Older Americans Act (OAA). In purely financial terms, Title III C comprises almost $450 million of planned expenditures for 1991, over 56.5% of total dollars allocated! In human terms, nutrition programs reach the greatest number of seniors of all Older Americans Acts programs. Accessible to the elderly in their own community, the program nourishes them physically, as well as socially, and emotionally. Many times each day, the personal visit by the meals-on-wheels volunteer (or driver), or interaction with others at a congregate site, is the only social contact for many elderly Americans. Conceived to alleviate malnutrition among the elderly, the program has flourished to provide vital support to seniors, a connection to other community services, and an opportunity to enrich their lives.

The Older Americans Act is continually evolving. This is induced by change in demographic characteristics of the elderly as successive cohort groups reach the age of sixty, and by the network struggling to re-define its role in serving the elderly. This emphasis has gradually shifted from services provided in a congregate settings to individualized, in-home services, and, from services that are preventive and supportive in nature, to those which are significantly more palliative.

This shift has been accompanied by a need for a higher level of skills in network staff. These services are also, by nature, higher in their cost. Without meaningful increases in funding for OAA programs, this has required the network to sacrifice some objectives to achieve others. Most notably, the congregate nutrition allocation has been used as the "bank" to underwrite necessary programs in other subparts of the Act.

This trend has led to a significant weakening of nutrition programs' ability to meet the demand for services, to assure high quality products, to employ qualified individuals, and to develop new services to keep pace with changing client preferences. Further erosion could seriously jeopardize the existence of many programs nationwide.

In the reauthorization process, NANASP strongly urges that the transfer of funds issue be reviewed. NANASP recommerds that each subpart of the OAA be adequately funded to meet its mission, and that transfers be held at their current dollar levels. Adequate resources for each subpart would end the necessity of the shell game performed with nutrition dollars. While throwing money at a problem is not always the answer, this is one clear instance where the infusion of additional funding would have meaningful and measurable impact on the condition of the vulnerable elderly. In the long term, maintenance of the nutritional status of the elderly could have significant economic benefit in health care cost containment.

Among the funding issues is the USDA reimbursement for eligible meals. This reimbursement needs to be adjusted annually to a cost-of-living factor in order to keep pace with food costs. Otherwise, it becomes just another way that programs are slowly eroded in their capability. Programs must be assured that their resources will keep pace with escalating prices.

NANASP also recommends that serious effort be given to develop, and fund, educational opportunities for staff at the service provider level. Because of economic realities, staff turnover is a problem, and most programs are able to provide only minimal training. In a system where services are requiring a higher degree of technical expertise, nutrition programs need to be strengthened to assure quality of service. We cannot permit a degradation in skills at the service provider level. Working with a population which is more at risk to food-borne illness, requires a greater emphasis on education and training. Furthermore, programs must be able to respond to the special dietary needs of the elderly resultant from chronic disease, medication, or illness. This dictates a staff that is knowledgeable in nutrition issues of the aged, and able to address the needs in their community.

Additional emphasis should be created on the preventive health benefits provided through balanced nutrition. The congregate programs should be a major conduit through which nutrition and health education is provided to the elderly population. Serving as a focal point in their communities, congregate nutrition services provide wide access to the senior population. Promotion of wellness is an assignment well-suited to the congregate program. National and statewide efforts should be instituted to take advantage of this opportunity.

Caution should be exercised that the Older Americans Act does not shift too greatly towards a medical model. Other government initiatives are geared to operate more effectively in this arena. The role of the OAA should be assessed carefully in order to design a system which complements, and supplements the health care system already in place, and does not compete with private sector services.

It is evident that some health care services are a natural part of the OAA network. Providing such alternatives to institutional care is an important function of the OAA. Great strides have been made over the past decade towards building a structure to administer such care, and to assure quality. Commendably, states and area agencies are moving rapidly to address these needs. But, we should avoid becoming overly restrictive and narrowly focused. We must turn our attention to the community services that underpin this system. The past decade has a detrimental effect to service providers nationally. Trimming of operations and staff induced by funding restrictions has left many in a weakened state. We must undertake the rebuilding of local capacity to meet increasing demand. We must find new ways in which to develop public and private resources at all levels to meet the needs of a growing population.

While we must concentrate on reaching seniors with the greatest needs, opportunities must be afforded to those seniors to participate who can afford to contribute their time, talents, knowledge, and money. The support and involvement of a broad spectrum of senior citizens is necessary, and desirable. Balance must be maintained to assure the broadest possible support for its mission. Through a sense of ownership, seniors help to develop and support the network, instead of merely being recipients of its benevolence. This has been the greatest strength of the OAA. The consumer oriented focus of the Act, its emphasis on grassroots planning, and its preservation of human dignity assure its continued success.

Item 4

NAMP
NATIONAL ASSOCIATION OF MEAL PROGRAMS
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TESTIMONY OF THE NATIONAL ASSOCIATION OF MEAL PROGRAMS REGARDING REAUTHORIZATION OF THE OLDER AMERICANS ACT

EXECUTIVE SUMMARY

The National Association of Meal Programs (NAMP), representing providers of both congregate and home delivered meals to persons 60 years of age and over and their spouses, makes the following recommendations regarding the reauthorization of the Older Americans Act (OAA) slated for Congressional action in 1991.

FUNDING

Administration on Aging (AOA) data for the 1989 fiscal year for Title III C-1 and C-2 programs are presented in the table below.

	Title III C-1 Congregate Program	%	Title III C-2 Home Delivered Program	%	Total
Unduplicated Persons Served	2,763,273	78	775,159	22	3,538,432
Meals	144,112,450	59	99,686,266	41	243,798,716
Appropriated $$'s before Transfer	356,668,000	82	78,546,000	18	435,214,000
Amt./Meal before Transfer	$2.475		$.788		$1.785
Allocated $$'s after Transfer	233,672,472 a	70	101,475,482 b	30	335,147,954 c
Amt./Meal after Transfer	$1.621		$1.018		$1.375

a $240,023,764 including education/training ($1,932,549), outreach ($3,481,815), and transportation ($936,928)
b $102,821,487 including education/training ($441,375) and outreach ($904,630)
c $342,845,251 if the services in a and b above are included

In light of the significant contribution congregate meals make to maintaining health and social interaction for the elderly and in light of the growing need for home delivered meals as evidenced by extensive waiting lists and limited home delivered meal service in rural areas, NAMP finds it unacceptable that the transfer of funds from the Title IIIC program has resulted in a decrease of over $92 million in funds available for meals. NAMP's position regarding funding policy is that Congress should:

1. Eliminate completely transfers between Title IIIB and Title IIIC and ensure that each part is adequately funded according to the level of need;

2. Limit transfer authority within Title IIIC from C-1 to C-2 or vice versa to transfers for the provision of meals and associated nutrition services only;

3. Mandate that AOA publish guidelines for allocation of Nutrition Program Assistance on a unit or per meal basis and require that state and area agencies on aging follow those guidelines;

4. Establish, as an entitlement for each provider, a minimum floor of assistance per meal ($1.75 is suggested initially with annual adjustments based on the Bureau of Labor Statistics' index of cost of food away from home) and then establish criteria through which the state and area agencies on aging can augment with Title III funds this minimum assistance level in view of legitimate operation cost differentials; and

5. Require that AOA direct the state and area agencies on aging to use existing programs efficiently and not to initiate new programs unless it is demonstrated that such programs will not duplicate existing non-profit programs.

TRAINING

The purpose of Title IV of the OAA (Training, Research and Discretionary Projects) is to improve the quality of service and to help meet critical shortages of adequately trained personnel for programs in the field of aging. Furthermore, in Sec. 307 (a)(17), the OAA states that state agencies on aging will provide training opportunities for personnel of agencies and programs funded under this act. In this regard, NAMP believes that there needs to be greater communication and coordination with private sector programs. Therefore, NAMP recommends that:

1. Language be added to the OAA allowing training opportunities for nutrition providers regardless of funding source; and

2. Such inservice nutrition training opportunities and courses of instruction be provided by utilizing existing public and non-profit senior meal organizations.

DONATIONS

Nutrition services for the elderly have a successful track record in emphasizing the value of a suggested donation from the client to the program in order to maintain and expand services. Data indicate that total client donations for meals have risen over the past decade, although it is not clear that per capita donations have increased. It appears that home delivered meal clients generally have less income and poorer health than congregate meal recipients. NAMP supports the concept of cost sharing as a way of increasing program resources but believes it should be administered with certain caveats. NAMP recommends that:

1. A federal initiative on some cost sharing for elderly services be undertaken;

2. A self-reporting mechanism by the client in conjunction with the initial intake assessment questionnaire be used rather that a means test;

3. Cost sharing be used in other elderly service programs, not only in those providing meals; and

4. A concerted outreach effort be made to have senior citizens who are eligible for food stamps use their stamps in their donations.

DIETARY AND OTHER STANDARDS

In order to promote and maintain good quality Title III C-1 and C-2 programs throughout the country, federal standards should be developed and promulgated to ensure at least a minimum level of program performance. Current operational standards, practices and procedures need to be reviewed and measured against such standards. Therefore, NAMP recommends that:

> A set of minimum standards be developed for Title III C-1 and C-2 programs that address issues including but not limited to menu planning, staffing, food service code conformance, staff training and development and client assessment and nutrition education.

USDA CASH/COMMODITIES

At present there is limited access to the 56.76 cents per meal in USDA reimbursement provided to senior meal programs for qualifying meals. This limitation is a function not of USDA regulations but those of the AOA. Furthermore, the USDA reimbursement rate is subject to an authorization ceiling, which in practice means that increased numbers of meals can result in a decrease in the rate of reimbursement. NAMP therefore recommends that Congress:

1. Provide for broader eligibility of senior meals programs for commodities or cash in lieu of commodities by imposing only the following criteria on local providers for them to qualify for the USDA assistance:

   a. They must be a non-profit or public agency;
   b. They must serve meals which comply with the nutritional standards as stated in the Act (currently 1/3 RDA)
   c. They must serve meals to those 60 years of age or older or their spouse; and all others as specified by the Older American Act;
   d. They must agree to audits of a-c above by the state unit or the area agency on aging and maintain the records necessary to show compliance with a-c above; and

2. Provide that the level of assistance per meal be indexed to the Bureau of Labor Statistics cost of food away from home and that this per meal assistance be re-cast legislatively as an entitlement.

STATUS OF COMMISSIONER ON AGING

The Older Americans Act should be amended to elevate the position of Commissioner of the Administration on Aging to Assistant Secretary within the Department of Health and Human Services

Item 5

NAMP
NATIONAL ASSOCIATION OF MEAL PROGRAMS
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MINIMUM STANDARDS FOR OLDER AMERICANS ACT NUTRITION PROGRAMS

The menus must meet 1/3 RDA as verified by means of nutritional analysis unless an exception is granted to a program by a state unit on aging.

Comments: The goal of verifying the minimum standard of 1/3 RDA is most accurately accomplished by a nutritional analysis of the menu. Standard computer programs are already available and many agencies have written their own programs. For those agencies without the use of a computer, a long hand method of determining a nutritional analysis is available called the Nutrient Standard Method or NSM. Although time consuming at inception, the analysis remains in effect indefinitely or until the RDA's are modified. Once a nutritional analysis is in place, changes in the menu are easily accommodated to verify all nutritional requirements in vitamins, minerals, and calories.

The meal pattern method of determining 1/3 RDA has been adopted in many states as an alternative methodology. The meal patterns that were once meant as a guide have become the rule. If the meal pattern is to be used, there should be a review of the appropriateness of its content. One area in particular that should be reviewed is the requirement of 3 ounces of protein from one source, i.e. the center of the plate entree. Three ounces of edible portion protein every day in combination with other parts of the menu is supplying more than is required to meet the 1/3 RDA and in some cases is almost twice the requirement.

This also may contribute more fat to the diet, increase plate waste, is not easily measureable in casserole dishes, and is the most costly item in the meal pattern.

Item 6

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Additional Nutrition Standards That ADA Endorses:

1. In consultation with geriatric nutrition research experts, state units on aging, areas agencies on aging, nutrition program providers and professional organizations such as the American Dietetic Association, National Association of Meal Programs, National Association of Nutrition and Aging Services Programs, AoA should research and develop guidelines which would integrate the following services into comprehensive nutritional therapy/intervention for special-needs populations: nutrition screening, nutrition assessment, nutrition care planning, nutrition/therapeutic diet counseling, therapeutic meals, meal supplements, and meal replacement products.

   Comments: Client's needs are becoming more complicated than ever before, especially since the Medicare Diagnosis Related Groups (DRGs) were instituted. The elderly are being released from the hospital in frail conditions and this is putting greater demands on care providers. Meal service alone is no longer able to address many of the participant's needs.

2. Health promotion programs shall include nutrition counseling and educational services provided by registered dietitians as a core component and adequate funding should be provided.

   Comments. A large portion of the elderly are healthy, vital, and want to stay well and functioning as long as they can. They have the ability to make decisions on how to live their remaining years and can take an active role in prolonging their good health. They need to have accurate information about the relationships between nutrition, exercise, and preventive health and disease. Misinformation regarding these issues can play a negative role in the health status of the elderly.

   The provision of accurate nutrition information and counseling by a registered dietitian is important as nutrition intertwines with many aspects of health and well-being. Preventive actions by the elderly can lessen the need for institutionalized care and allow them to age in place.

For additional information contact Julie Stauss, RD, Manager, ADA Division of Government Affairs at 202-371-0500.

2/15/91

Item 7

SOCIETY FOR NUTRITION EDUCATION

Nutrition Issues in Revising the Older Americans Act

The Society for Nutrition Education is the premier association which links the fields of nutrition and education. The Society recognizes that good nutrition as part of health promotion can slow the rate of degeneration associated with aging and foster the independence and well-being of older individuals. To this end, the Society suggests attention be paid to the following issues in revising the Older Americans Act.

1) Older Americans should have access to meals through Title III of the Older Americans Act which follow the 1990 USDA/DHHS *Dietary Guidelines for all Americans*

2) Administrators of the Title III programs should receive adequate training in nutrition and nutrition education to be able to assure meals and nutrition education follow the principles of the *Dietary Guidelines*

3) Nutrition and fitness education and counselling should be mandated as a separate budget line item under Title IIIc and required in both the congregate and home-delivered meals programs, and these programs should be designed to meet the diverse needs, nutritional status, and living situations of older adults.

4) The *Dietary Guidelines* and the related USDA materials designed for older people should be made available to all participants in the Title III meals programs.

5) Credentialed nutritionists[1] be employed as staff in agencies involved in administrating aging programs at all levels of the Federal and State government.

6) Service providers in programs under the Older Americans Act should inform participants about other nutrition and social program benefits to which they are entitled.

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[1] Credentialed nutritionists are registered dietitians or individuals with graduate degree from an accredited nutrition program.

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Item 8

NUTRITION STRATEGIC STUDY

A REPORT TO THE
DIRECTOR OF
THE OHIO
DEPARTMENT OF AGING

PREPARED BY THE
NUTRITION STRATEGIC
STUDY COMMITTEE

JULY, 1989

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BIBLIOGRAPHY

NUTRITION STRATEGIC STUDY COMMITTEE

*Department of Aging Staff Membership**

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CHAPTER ONE

INTRODUCTION

Ohio's aging network in its quest to develop a responsive and efficient community based long term care system is faced with examining some long standing programs and practices. Such inspection is necessary to enable the Ohio Department of Aging (ODA) and others to assess the current environment and make informed decisions on policy and programmatic issues impacting on a community-based long-term care (CBLTC) system.

One such crucial programmatic area is nutrition. As outlined later in this report, nutrition and the various components which comprise "nutrition services", e.g., meals, education, assessment, play an important role in community-based long-term care (CBLTC). With research indicating that 50 percent of those elderly living in the community have nutritional deficiencies, coupled with an increasing older population and greater emphasis on offering community-based options, it is clear the time is right to review ODA efforts in providing nutrition services and outline the course of action for the future.

To this end, a Nutrition Strategic Study Committee was formed in September, 1988 in response to a request from the Director of the ODA, Dr. Carol Austin, to examine and develop recommendations on the role of nutrition services in a developing long-term care system. Specifically, the Nutrition Strategic Study Committee was charged with addressing the following questions:

- Are nutrition services substantially different from other in-home or community-based programs?
- How does targeting affect the provision of nutrition services?
- What subpopulations of elders benefit from nutrition services?
- What kind of nutrition expertise should Area Agencies on Aging (AAA) have on staff?

This report therefore attempts to offer responses to these questions and recommendations for consideration as ODA and the aging network move forward in the establishment of a comprehensive community-based long-term care (CBLTC) system.

CHAPTER TWO

LITERATURE REVIEW

NUTRITION SERVICES FOR OLDER ADULTS

The Need for Nutrition Services

The increasing number of non-institutional elderly that are not able to plan, shop, and/or prepare meals is of growing concern, in particular the frail and homebound elderly. The literature indicates that many older adults are at a nutritional risk. Studies have suggested the existence of specific nutritional deficiencies in as much as 50 percent of the independent living elderly in the country (Goodwin et al., 1983). Diseases commonly found in the older adult population that are possibly affected by diet include diabetes, hypertension, cardiovascular diseases, osteoporosis, and anemias. Increased research efforts have been targeted to identify the role of nutrition and diet in chronic disease prevention. However, after developing any one of these chronic diseases, and many elderly suffer from multiple chronic diseases, the need for food and nutrition in the form of diet therapy is now often used by the physician as the first method of treatment. If treatment is not successful with diet modifications alone, diet therapy becomes secondary only to drug therapy. Polypharmacy problems, common in the elderly, also frequently lead to new nutrition complications necessitating a close watch for nutrient-drug interactions which can lead to further diet, health and medical complications (Chapman & Sorenson, 1988; Roe, 1983; Watson, 1985).

The importance of nutrition relative to well-being has been emphasized throughout the literature. As Posner and Krachenfeld noted in their article, "the benefits of balanced nutrition in adulthood also include the prevention or delayed onset of certain chronic diseases and their complications; better management of medical conditions; improved recovery from trauma and illness; better resistance to infection; maintenance of independent living; and potential savings in the cost of medical and institutional care, surgery, and drug therapy" (p. 261). In fact 85 percent of the older adult population has one or more chronic diseases that have been documented to benefit from therapeutic nutrition intervention (Committee on Education and Labor, 1982; Roe, 1983).

Malnutrition, including hunger and nutrition deficiencies is very prevalent among older adults (Posner & Krachenfels, 1987). The Flagstaff Medical Center in Flagstaff, Arizona reports extensive coding for existence for malnutrition depending upon the type and severity of the malnutrition identified. These malnutrition codes are significant co-morbidity for intestinal/abdominal diseases, orthopaedic surgeries, carcinomas and lymphomas, peripheral vascular disease and pneumonia, all common diagnoses for significant numbers of the elderly (Myers, Landye & Kovacsics, 1989).

Sullivan et al. (1988) found over one-third (39%) of elderly men admitted to a VA hospital were, upon admission, at high risk for clinically significant protein-energy malnutrition and those at-risk patients had a longer length of stay in the hospital compared to low-risk patients. At a conference in Columbus, Ohio in June, 1989, David Lipschitz, M.D., Ph.D., (Geriatric Research, Education and Clinical Center in Little Rock, Arkansas), discussed the high prevalence of protein-energy malnutrition in the elderly. Lipschitz described the onset of protein-energy malnutrition in the elderly as quick in the face of surgery or illness, because unlike younger adults, the elderly have reduced protein stores that are easily depleted (usually within 3 days), leading to protein-energy malnutrition as their bodies struggle to respond to the large protein and calorie needs for healing. In a study identifying risk factors affecting medical complications in the elderly, Lipschitz found that even after controlling for all non-nutrition variables, malnutrition was significantly correlated to the incidence of medical complications (Lipschitz, 1989).

At this same conference Daphne Roe, M.D., noted researcher in geriatric nutrition, (Division of Nutrition Sciences, Cornell University), also described risk factors for identifying elderly individuals likely to be hospitalized. From her work, hypertension, diabetes, poverty, loss of mobility and bed-bound status are the most significant predictors. In a comparison study in New York state, Roe found that between two groups of elderly diabetics, the group receiving home-delivered meals suffered less hospitalizations than the group not receiving home-delivered meals. And although not yet published, Roe has also researched and identified a set of factors used to develop a "neglect score", predictive of the incidence of hospitalizations or rehospitalizations. At the top of the list is the lack of home-delivered meals, followed by the lack of a hospital discharge plan, lack of special diets and finally the lack of home-health aide services. Roe reports findings from another study in New York that identified that 25% of the frail homebound elderly in the study, were found to have eaten adequate meals less than 7 days per week and 16% went one or more days each week without any food. According to Roe in her native country, England, before retirement, all aging citizens are eligible to go to their health care centers specifically for a complete nutrition assessment and nutrition care plan. However, in any nation, Roe contends that the most important single factor in preventing malnutrition and its devastating health and medical complications in the elderly, is the elderly person's ability to access food (Roe, 1989).

Malnutrition is considered avoidable if the opportunity to consume nutritious diets is made available. It is known that poor nutrition increases health problems, increases use of health care services, and thereby, increases health care costs. Wolinsky (1983) in a study of health services utilization among noninstitutionalized elderly, found nutritional risk as the most important predictor of the total number of physician visits, visits to the physicians in emergency rooms and the occurrence of hospital episodes. In short, the current attention toward the nutritional needs of older adults could possibly contribute to a slowing in the rapid rise in future health care costs.

Nutrition Policy for Older Adults

Efforts for meeting nutritional needs for older adults initially began at the local level with community and civic organizations instituting their own congregate and "meals on wheels" dining. However, at the federal level, efforts have been expressed through a number of nutrition programs: food stamps, the commodity supplemental food program, congregate meals, and home-delivered meals. Although the food commodity and food stamp programs instituted in the 1960s were not developed specifically for older adults, they were made available to older adults.

Nutrition policy mandated specifically for older adults first appeared in the 1965 Older American's Act (OAA) (Title IV). This initial policy involved congregate dining. The 1972 amendments (Title VII) to the Older Americans Act involved expanded congregate dining and the creation of the National Nutrition Program for Older Americans. Still further amendments (Title IIIC) created the home-delivered meals program and made the Area Agencies on Aging responsible for the administration of meal service delivery at local levels. The home-delivered meal program was focused towards special groups of older adults -- the frail and homebound elderly.

The national Nutrition Program, now the Title III Elderly Nutrition Program, was developed to provide meals and nutrition education to older adults. The purpose of the program was to:

> provide older Americans, particularly those with low income, low cost, nutritionally sound meals served in strategically located centers...where they can obtain better social and rehabilitative services. Besides promoting better health among the older segment of the population through improved nutrition, such a program is aimed at reducing the isolation of old age, offering older Americans an opportunity to live their remaining years in dignity (Federal Register, 1972, p. 16845).

Given the initial congregate format, the program was designed: (1) to serve as a meeting place where older adults could receive a nutritious meal and nutrition education (2) to provide an opportunity for socialization and recreation. Later provisions were also made in the act in regard to nutrition content of meals, "special diets", program administration, and participant donation policy. Over time, however, the primary focus remains meal service and not comprehensive nutrition services.

In 1987, amendments to the Older Americans Act placed greater emphasis on targeting services to low-income and minority elderly as well as the "frail" elderly and their need for more in-home services. The Older Americans Act defines the term "frail" as "physical or mental disability ... that restricts the ability of the individual to perform daily tasks or which threatens the capacity of an individual to live independently". (Older Americans Act, 1987).

This new emphasis on serving the frail elderly now places a burden on a national meals program that has never been mandated to emphasize home-delivered meal service or to provide more comprehensive and specialized nutrition services, often needed by more debilitated clients.

Delivery of Nutrition Program Services

Program options and delivery mechanisms

Current nutrition program services under the auspices of the Title III Elderly Nutrition Program include foodservice, education, and "special diets". The primary service provided is meals, with most programs providing nutrition education, some programs providing special menus for ethnic and cultural groups and a few programs offering shopping assistance and therapeutic diets (ODA Nutrition Study Committee, 1988; Posner & Krachenfels, 1987). However, the provision of comprehensive nutrition services, including nutrition assessment and other therapeutic and clinical services, is virtually non-existent.

The two primary mechanisms for meal delivery are congregate dining and home-delivered meals. Congregate nutrition sites are most typically located at senior centers, religious facilities, and public housing and actual meal preparation consists of combinations of on-site production, central kitchen production, and caterer contracts (Balsam & Rogers, 1988).

Nutrition Program Staff

Staffing for the various nutrition programs include administrative and professional staff such as nurses, social workers and consultant dietitians and nonprofessional paid staff and volunteers (Roe, 1983). Volunteers are used to assist in the provision and delivery of meals. There is no research to indicate optimum staffing levels and composition for home-delivered meal and congregate programs. The Older Americans Act and regulations provided by the Administration on Aging have never included optimum staffing recommendations perhaps because nutrition programs across the nation can vary widely in their method of meal production, service delivery geography and volunteer staff support.

Use of Nutrition Program Services

Beneficiaries of services

The beneficiaries of Title III Elderly Nutrition Program services are persons 60 years of age and over and their spouses (regardless of age). For congregate services the primary eligibility requirement is age. Legislation is directed towards those older persons in greatest economic and social need. However, much emphasis has been placed on service provision to those groups who are underserved: frail, home-bound, isolated, low-income, and minority older adults. The extent to which these groups have benefitted from the program is held in question (Austin, 1987).

Extent of Nutrition Program Service Use

Older adults' use of the first federal community-based nutrition services (food stamps and food commodities) was low. Revisions were made to the Food Stamp program to accomodate older adults, but participation was still relatively low in comparison to the eligibility numbers. The elderly's participation in these programs continues to be low due to pride and unfamiliarity with and/or patience for service access.

Nationally, there are approximately 1350 Elderly Nutrition programs that receive federal funding and are involved in both congregate and home-delivered meals (Balsam & Rogers, 1988). The number of meals served through this program in 1986 ranged from 2250 to over 5 million. The average number of meals served per program was about 207,000.

Balsam's study found growth most among the number of home-delivered meals. However, the number of clients served depends on a number of factors. In regard to program use differences, Harel (1985) found minor variations between white and black elderly, but Balsam and Rogers (1988) concluded the minority elderly are among those elderly who are underserved.

Evaluation of Nutrition Program Service Delivery

Evaluations of nutrition program services have provided descriptions of nutrition programs at the state level and have provided profiles of service delivery nationwide (Aging Health Policy Center, 1983; Balsam & Rogers, 1988, Bechill & Wolgamont, 1972, DHEW, 1978; Harel, 1987; Kirschner Associates, 1982, 1983; Posner, 1979; Senate Committee on Nutrition & Human Needs, 1976). More specifically, studies have examined goal attainment, program impact, performance gaps relative to target groups, and service delivery strategies.

Overall, findings have been positive, but those in regard to nutritional impact have varied. Some unmet needs were identified, including service provision for the frail, homebound, and minority group elderly and extended meal provision and special diets.

SUMMARY OF THE REVIEW

Major Issues

Throughout the literature a number of major issues surfaced. These issues involved policy and service delivery. More specifically, the issues were: (1) the relationship between nutritional intake and health services use, (2) service innovations, (3) nutrition assessments, (4) staff training and education, (5) cost-sharing mechanisms, and (6) role of nutrition in community-based long-term care (CBLTC).

- Although most agree nutrition intake affects morbidity, mortality and the use of health care services, thereby health care costs; data (beyond that already published for total parenteral nutrition (TPN) therapy) supporting a substantial relationship between nutrition services intervention (less aggressive than TPN) and patient outcome is needed. (Chapman & Sorenson, 1988; Balsam, et al., 1985; Bartlett, 1988; Balsam & Rogers, 1988; Lipschitz, 1989; Myers Landye & Kovacsics, 1989; Wolinsky, 1983).

- Legislation mandates service to those in greatest economic and social needs, but needs still go unmet for particular elderly persons and situations. Service and target innovations are needed to approach deficits in serving particular elderly groups (FRAC, 1988; Ellegard & McCollum, 1983; Balsam & Rogers, 1988; Balsam, et al., 1985).

- At the present training and educational emphasis in nutrition are focused primarily on food service management. Training and/or education should incorporate clinical dietetics given the link between nutrition and health (Balsam & Rogers, 1988; Balsam, et al., 1985; Ellegard & McCollum, 1983).

- Increased client-sharing in the cost of meals is considered a viable cost-containment strategy. Greater effort should be directed towards enforcing the client donation policy (FRAC, 1988; Chapman & Sorenson, 1988; Posner & Krachenfels, 1987).

- Nutrition screening and assessment should be an integral part of the nutrition program services package. Expertise and standardization of tools and procedures are much needed (Chapman & Sorenson, 1988; Bartlett, 1988).

- The inclusion of meal services but not comprehensive nutrition services, as part of community-based long-term care (CBLTC) was addressed throughout the literature. To some, home-delivered meal service is considered part of the continuum, but not congregate meals. Home-delivered meal service is included due to its large number of impaired users. However, those who look beyond the feeding component see nutritional screening, assessment and other nutrition services (e.g., nutrition intervention planning, counseling, and education, etc.) equally a part of this continuum of health services. The current system needs changing to link nutrition to the community-based long-term care (CBLTC) delivery network. More specifically, nutrition professionals should be involved in the delivery of health and related services. Also, revisions of federal and state regulations and specifications are needed to incorporate these services into the continuum (Bartlett, 1988; Kane & Kane, 1987; Posner & Krachenfels, 1987; Balsam & Osteraas, 1987).

Recommendations

Specific recommendations from the various reports and studies were as follows:

- Conduct systematic evaluations of nutrition programs;
- Increase funding for program development, expansion, and outreach;
- Continue the development of service and target innovations for underserved groups of elders;
- Continue the review of nutritional guidelines;
- Assure education and training of persons at all levels of program development and implementation;
- Review client donation policies;
- Conduct research to determine program outcomes;
- Review eligibility criteria;
- View nutrition as a therapeutic modality, not simply a domiciliary service.

CHAPTER THREE

ELDERLY NUTRITION SERVICES IN OHIO

As indicated in the literature review, national recognition and subsequent funding for nutrition services for the elderly stem primarily from the Older Americans Act which provides support for congregate and home-delivered meals. In Ohio, federal Older Americans Act funding spent statewide by the Area Agencies in 1988 totaled $26.4 million, with $3.8 directed to home-delivered and $9.7 million used for congregate meal services. Another $7.2 million in general revenue funds, United States Department of Agriculture, Social Services Block Grant and other revenue sources were utilized by the Area Agencies on Aging (AAA) and nutrition service providers for home-delivered meals with $9.4 million from similar sources for congregate meals.

Such funding translates into over 4.3 million congregate and 3.2 million home-delivered meals served to approximately 87,500 unduplicated congregate and 28,000 unduplicated home-delivered meal clients. Thus, in 1988, of Ohio's 1.4 million 60+ population, 6.25 percent received congregate meals with 2 percent utilizing home-delivered meals. While congregate services account for 57% of all meals served, this represents a decrease from the 68% of all meals served in 1986, indicating a shift on the part of the Area Agencies on Aging to direct funds in a larger proportion to home-delivered meals. Across Ohio's twelve Planning and Service Areas (PSA), home-delivered meals as a percentage of total meals served range between 30 and 50 percent in 1987.

In terms of targeting nutrition services to elderly subpopulations, statewide information reveals that 14.4 percent of the 1988 home-delivered meal clients and 12 percent of congregate clients were minority clients. Moreover, nearly 60 percent of the home-delivered clients were low-income, with 48 percent of congregate clients being of low-income. However, such low-income figures must be considered in the context that many nutrition providers do not collect income information but rather estimate who is low income by their knowledge of the individual clients. This practice has been followed by many providers due to their interpretation of the Older Americans Act provision disallowing means testing. Even with the substantial percentage of low-income and minority clients as percentages of total nutrition clients, home-delivered meal services are only reaching 3 percent (and 9 percent for congregate) of the total 60+ minority population and 5 percent (and 14 percent for congregate) of the total 60+ low-income population.

The data also indicate that the ODA-funded nutrition service system (not including PASSPORT Program* funded meals) has a daily capacity of approximately 16,675 congregate and 12,229 home-delivered meal clients, using a one-meal-a-day, five-day-a-week service schedule. The average length of time for clients to receive meals, using this one-meal-a-day, five-day-a-week service as the standard, is 2.3 months for congregate and 5.3 months for home-delivered meals. In examining these average length of time figures, one must consider that there is great variability in delivery schedules among providers, e.g., a few congregate meal sites and some "split" sites may only serve noon meals one or two days a week.

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* PASSPORT (Pre-Admission Screening System Providing Options and Resources Today) is the State of Ohio's community-based long-term care program.

With the successful passage of ODA's 90/91 biennium budget, the state's commitment to home-delivered meals will increase from a biennial total of $1,034,300 to $5,622,460, with a resulting increase in the daily capacity for home-delivered meals. It is important to note that the daily capacity calculation is based on one-meal-a-day, five-day-a-week schedule. Thus, any service delivery changes adopted by nutrition providers such as two meals a day; seven-day-a-week delivery; and therapeutic meals as a result of increased funding and needs of the long-term care client, will impact on the daily capacity figure.

While the above data portrays statewide funding and service patterns, it became evident in the Committee deliberations that information on the operations of existing nutrition providers was lacking. Such information was thought to be needed in terms of examining the current status of nutrition providers and projecting the impact of recommendations developed by the Committee on such providers and the nutrition service system. This recognition lead the Committee to survey in January, 1989 Ohio's existing nutrition service providers. The survey centered on the following areas:

- client characteristics
- nutrition service provider characteristics
- service eligibility criteria
- client assessment tools and processes
- provider prioritization of needed nutrition services
- provider identification of nutrition service issues
- provider identification of staff training needs

A copy of the survey instrument with response tabulations can be found in the Appendix. Of the 98 surveys distributed, 81 were completed and returned.

Nutrition Providers

Survey data indicated that the majority of providers (88%) are non-profit agencies with the remaining 12% of respondents being governmental entities. Nearly half (49%) of the respondents are senior centers. Community action organizations (23%) and nutrition service agencies (where nutrition is the sole service provided) (11%) account for the second-and third-largest categories of providers responding to the survey. Nearly all respondents (99%) provide congregate meals with 91% providing home-delivered meals, 89% offering nutrition education and 54% supplying shopping assistance. Nutrition providers have been providing services, on average, for thirteen years.

In terms of funding, Title IIIC of the Older Americans Act funds were available to 95% of congregate and 88% of home-delivered meals providers. In addition to client contributions and United States Department of Agriculture revenue, home-delivered meal providers also enjoyed other funding sources including Social Service Block Grant (30%), United Way (14%), Assistance for Independent Living (21%), local tax levy (7%), fund raising (14%), and corporate donations (5%). The variety of funding sources for congregate meals is not as prevalent as with home-delivered meals, with fund raising (16%), Social Service Block Grant (9%), and local tax levy (7%) being the most frequently cited sources (in addition to Older Americans Act.)

Nutrition Services

With the thrust toward expansion of community-based long-term care, an increased need for service availability and expansion of nutrition options is expected. It is interesting, therefore, to note that weekend home-delivered meals are provided by 28 percent of providers on Saturdays and 27 percent on Sundays. The prevalence of acute and chronic health conditions and concurrent impairments among the elderly calls for nutrition options tailored to particular needs. Of fifteen options listed in the survey, information and referral, and acceptance of food stamps in lieu of cash donations were provided by the majority of providers. In addition to these services, the most frequently-occurring services are modified or special diets (41%), commodity distribution (41%), holiday meals (31%), weekend meals (27-28%), and regular visits by nursing home residents to nutrition sites (26%). Providers also indicated that of services they do not currently provide, the following are options that they either receive a significant number of requests for or options that they consider priorities in meeting the elderly's nutrition needs: weekend meals (61%), modified or special diets (58%), and supper option for home-delivered meals (27%). Fourteen percent of respondents indicate they have a waiting list for congregate meal service with an average 2.3 week waiting period. Correspondingly, 33 percent of surveyed agencies responded that they have a home-delivered meal waiting list with an average wait among the surveyed agencies of 4.3 weeks.

Staffing among nutrition providers varied greatly with a median of 5.8 full time equivalents (FTEs) and a median of 17 volunteers. Among the 81 respondents, there were only a total of 8.75 FTE staff licensed registered dietitians. Such staffing has implications as providers move to offering standardized assessment and more sophisticated meal options to meet the long-term care population nutritional needs. Seventy-five percent of respondents indicate they have a formal in-home assessment process administered face-to-face with potential home-delivered meal clients. However, only 42 percent of respondents indicate that they have written home-delivered meal client prioritization process/tool/criteria. Over half of respondents (52%) portray that outreach workers perform the actual assessment of home-delivered meal clients with other staff performing this function as follows: site manager/coordinator (49%), other health/social service worker (27%), licensed social worker (25%), registered nurse (7%), and registered dietitian (1%).

Nutrition providers were responsive in outlining issues they face in providing services to the elderly. These issues include:

1. challenges of transporting meals and clients including adequate staffing, volunteers, vehicles and insurance to meet even current service demands and to reach isolated and rural areas;

2. lack of funding for expanding program-service options such as 7-day-per-week meal service, multiple meals and therapeutic meals;

3. difficulties in developing appropriate and adequate home-delivered meal eligibility assessment procedures, the lack of staff to perform reassessments while keeping pace with the growing demands to perform greater numbers of initial assessments and more complicated initial assessments;

4. program administration challenges such as rising costs for staffing and food and equipment, the lack of funds for computer systems to allow for more sophisticated home-delivered meal route scheduling (making the program more responsive to client and family needs);

5. lack of funding for increased staff and for more highly-skilled staff to perform assessments and outreach to locate the very isolated clients targeted for service in the Older Americans Act.

Training needs voiced by respondents covered a variety of topics ranging from health and clinical nutrition issues to food service operations to overall program administration including fundraising, marketing, staff training, public relations, program service standards and volunteer recruitment and development. The diversity of topics provide fertile ground for ODA, AAAs, statewide nutrition organizations and others to collaborate and coordinate on developing and offering training opportunities for the nutrition provider network.

CHAPTER FOUR

NUTRITION STRATEGIC STUDY ISSUES & RECOMMENDATIONS

The study committee was charged with addressing four questions posed by ODA Director Carol Austin. To repeat, these questions are as follows:

- Are nutrition services substantially different from other in-home or community-based programs?
- How does targeting effect the provision of nutrition services?
- What subpopulations of elders benefit from nutrition services?
- What kind of nutrition expertise should Area Agencies on Aging have on staff?

Before the committee fully discussed aspects of each of these questions, members discussed the importance of defining the term "nutrition services" and identifying (eventually accomplished through the study provider survey) which of these services are available through ODA-funded nutrition programs.

Defining "Nutrition Services"

Over the course of several meetings committee members discussed the term "nutrition services". Nutrition services, whether delivered in the client's home or in an institution, constitute more than simply the provision of a meal or meal preparation and delivery. Comprehensive nutrition services now available in long-term care institutions, and which could be made available for incorporation into the community-based long-term care (CBLTC) continuum, include the following:

1. individual client screening for identifiable nutrition/nutrition-related problems and the client's need for comprehensive nutrition assessment;
2. individual client nutrition assessment;
3. individual client nutritional status monitoring;
4. individual client nutrition intervention planning and management with care plan development including:
    a. determination of the client's basic dietary needs (normal or therapeutically or texturally modified);
    b. determination of the client's need for any meal replacement products or nutrient fortified supplement(s);

   c. determination of the client or care giver need for nutrition/food, food preparation and behavior change information and education;

5. meal service including normal and therapeutic meals;

6. enteral (meal supplement or total meal replacement) or parenteral (meal supplement or total meal replacement) nutrition;

7. individual client/care giver or group normal and therapeutic nutrition counseling;

8. nutrition intervention monitoring and evaluation (Bartlett, 1988; Posner, 1987; Roe, 1983; ODA Nutrition Study Committee, 1988).

ODA Funded Nutrition Program Services

As discussed earlier in this report the primary focus of elderly meals programs across this country has been meal provision with little movement toward more comprehensive nutrition services. Similarly Ohio's nutrition program for the elderly was found by the study committee to be limited in the number and variety of nutrition services offered. To highlight and emphasize survey information summarized previously in this report, some survey findings will be repeated here.

In the tradition of the OAA and within the constraints of Title III funding, no Ohio nutrition provider offers comprehensive nutrition services. As expected over 90% do serve congregate and home-delivered meals five days per week. Surprisingly greater than one fourth (27-28%) offer weekend home-delivered meals. Yet only 4% offer any weekend congregate services and slightly over 30% provide meal service on holidays. Less than half (41%) offer what the survey termed as "modified or special" diets. However, a modified or special diet can mean as little as the change from a sugar-sweetened dessert to fresh or unsweetened canned fruit. ODA staff report that very few of Ohio's nutrition providers offer any variety of clinical therapeutic meals.

89% of the providers surveyed indicate they offer some form of nutrition education service. This is typically basic group education activities and does not include therapeutic diet counseling. Over half (54%) stated they also provide shopping assistance. Given the high cost of this service if it includes food selection assistance and consumer education information, it is likely these providers are incorrectly calling transportation to the grocery, shopping assistance.

The ODA survey of nutrition providers did not ask whether nutrition programs have been providing more clinically oriented nutrition services such as nutrition assessment, nutrition care plan development and therapeutic diet counseling. However, ODA staff are unaware of any ODA-funded nutrition program, including those serving PASSPORT clients, that have moved into these service innovations. Some limited therapeutic diet counseling has been available sporadically through several programs across the state. Interviews and telephone interviews with 8 other state-level elderly nutrition program administrators revealed similar circumstances (ODA, 1989).

Currently, the Ohio Department of Human Services has included comprehensive nutrition services in their Home and Community Based Service (HCBS) Waiver II Program (for persons diagnosed with acquired immune deficiency syndrome and AIDS-related complex). This HCBS program mandates in-home nutrition consultation, provided by a registered dietitian, including nutrition assessment, nutritional care intervention with food and supplements provided through home-delivered meal service and nutrition education and counseling. The summary of this comprehensive nutrition in-home service states, "Nutrition services are necessary to avoid institutionalization of the clients" (ODHS, 1988).

Conclusions

With ODA's expanding role in CBLTC, the nutrition study committee discussed expansion in the number of home-delivered meals served, expansion in home-delivered meal service options and the need for ODA to add more comprehensive nutrition services to its existing CBLTC systems and any future CBLTC model programs.

Committee Recommendations

1. ODA needs to provide appropriate training for all AAA and ODA-funded nutrition providers for developing strategies for increasing nutrition service options.

2. ODA needs to facilitate nutrition provider networking with other innovative service providers to develop strategies for increasing nutrition service options.

3. ODA should continue to seek additional funding to expand nutrition services and provide training for AAAs and ODA-funded nutrition providers on methods of fund raising to expand nutrition services.

4. ODA should pursue funding for and develop one or two pilot programs that formally incorporate nutrition screening, assessment and as comprehensive nutritional care intervention as possible into the PASSPORT program and any future CBLTC model programs.

Nutrition Strategic Study Questions and Recommendations

Various aspects of all four study questions, cited earlier, were discussed by the strategic study committee. What follows is a summary of the committee's discussions, findings and recommendations based on those findings for each question.

A. Are Nutrition Services Substantially Different From Other In-Home Or Community-Based Programs?

Nutrition Services: Critical to Life and Health

Nutrition services are most similar to medical, nursing and pharmaceutical services because of their direct and immediate impact on the client's health or medical condition. Therefore as much as certain "other" CBLTC services, often classified as "social support" services, do not have as direct an impact on the client's immediate health or medical condition, then in one way nutrition services are just that different from those "other" CBLTC services.

In a recent review of the literature and in her testimony before the Ohio Governor's Home and Community Care Council, Professor Betty Bartlett (1988) found that CBLTC appears to be generally thought of as a social maintenance service for those individuals that are functionally impaired. Consistently she found a lack of understanding about the relationship between CBLTC meal service and its impact on maintaining a client's health. Kane (1987) describes LTC as "sitting uncomfortably on the boundary between health and social services and includes elements of both". Nutrition experts, trained to understand the relationships between nutrition services and total "well-being", are quick to point out that nutrition services, including food purchasing, food preparation, clinical assessment and modifications of diet and the act of eating alone or with others has a profound impact on a client's physical, psychological and social health (Posner, 1987; Roe, 1983; U.S. DHHS, 1988).

Professor Bartlett, the ODA Nutrition Administrator and other Ohio licensed dietitians have found that the administrators of LTC programs, both community-based and institutional, have tended to view meal service as a personal support service or as a residential service. This view alone can create problems and gaps in service, especially in policy-making for a health-impaired population, because this view can miss the most critical and basic need for food, which first and foremost is life, and second is for stabilized and improved health. As well as a personal care service, CBLTC meal service is a health service, because if the ability to prepare and consume adequately nourishing meals is only slightly impaired in a debilitated elderly population, the risk of the development of malnutrition and a rapidly debilitating health status becomes very great (Lipschitz, 1989; Posner, 1987; Roe, 1983; Roe, 1989; U.S. DHHS, 1988).

Nutrition professionals have found that recommended and existing systems for determining eligiblity and priority of clients for CBLTC services, including meals, are based on the assessment of a client's functional status including the identification of impaired instrumental activities of daily living (IADLs) and activities of daily living (ADLs). To illustrate this type of system consider the following recommendations, taken from the report titled "Federal Long Term Care Reform: A Proposal By The National Association of State Units on Aging":

> "BENEFIT DETERMINATION"
>
> Functional status should be the primary criterion for determining eligibility for (CBLTC) program benefits. A comprehensive assessment shall measure a person's ability to consistently and appropriately perform essential activities of daily living (bathing, dressing, toileting, eating, transferring) based on the person's physical, cognitive and emotional/behavioral functioning and shall review health conditions that may require in-home services. An assessment finding that the person's functional disability results in the need for human assistance in performing two of the five specified activities for daily living will result in eligibility for program benefits" (NASUA, 1988).

The problem with such a scoring system, as Ohio's nutrition professionals have discovered and reported to the ODA Nutrition Study Committee, is that not all activities of daily living are independent of each other and not all carry equal weight in life-threatening outcomes for the client. For example, needing assistance with dressing is important but not life threatening if the assistance is inadequate. However, needing assistance to access food is life threatening if assistance is inadequate (Lipschitz, 1989; Roe, 1989).

Any system for assessing client priority for service that bases eligibility and priority on the client needing assistance in performing two or more ADLs, ignores that if the only impaired ADL is life threatening, that client could be considered a higher priority for service than the client with two impaired ADLs that are not life threatening. As Bartlett (1988) states in her testimony to the Ohio Governor's Home and Community Care Council, "It may be too simplistic to say that the person impaired in three out of five ADLs is more impaired than the person (impaired) in two out of five ADLs. If eating is impaired, even if that is the only impairment, that person will die if adequate assistance is not provided". This fact makes nutrition services quite different from some other CBLTC services.

Committee members also discussed that assessing functional status and impairments of IADLs and ADLs alone cannot assess any client's total needs for nutrition services. Identifying impaired IADLs and ADLs cannot address the relationships that often exist between a client's short-term or long-term impairment and a client's anorexia, weight loss, nutrient/drug problems, fluid needs, vitamin or mineral needs, caloric needs, need for therapeutic meal modification(s) or any other nutritional and physical health related need.

However, an assessment of functional status and impaired IADLs and ADLs is appropriate to determine if a client can or cannot secure and prepare food and feed him or herself. Therefore, measuring functional status can serve as our best indicator for which clients need intervention for food. Once that has been determined, however, a measure of impairment alone cannot tell us which of those clients are at greater nutritional and health risk and of higher priority to receive food or any other important nutrition service defined previously in this report (see page 13) (Bartlett, 1988; Kane, 1987; Posner, 1987). Only a comprehensive assessment that includes a comprehensive nutrition assessment will adequately assess the client's total need for comprehensive nutrition services.

It is understood that many functional assessments, including that utilized by Ohio's PASSPORT Program, reviews multiple aspects of a client's functional, health and environmental conditions to determine the client's care needs. In PASSPORT, these areas include medication profile, health assessment, nursing and therapeutic interventions, informal care support, behavioral assessment, mental health assessment, mental retardation/developmental disability assessment, home environment assessment, psychosocial assessment and care giver assessment. Even in this comprehensive of an assessment process, a comprehensive nutrition assessment completed by trained nutrition professionals is missing. Additional elements can be added to existing client assessment tools such as a nutrition screen section completed by the assessment team which includes a nurse. The nutrition screen information can then be utilized to determine if a further comprehensive nutrition assessment, conducted by trained nutrition professionals, is warranted.

Included in the appendix of this report is one example of a nutrition screening tool and two examples of nutrition assessment tools (ODA, 1981; ODA 1989; Tramposch & Blue, 1987).

Congregate Nutrition Services: A Long-Term Care Service

Congregate meals are often thought of as a "preventive" service versus "support" service. And in recent years with growing concern over a growing federal budget deficit, there has been increased discussion about which types of services in the aging network should be given priority funding. Yet irrespective of the location of the meal service, (served at a congregate site or in a client's home), the provision of adequate nourishment is critical to preventing deteriorating health status in any stage of health and life for all elderly.

The committee heard from ODA nutrition staff that there is a tendency for persons not familiar with either the congregate or home-delivered nutrition program, to stereotype congregate nutrition program participants as the "well elderly" and home-delivered clients as frail and ill. And yet, a 1988 telephone survey of Ohio nutrition providers indicates that the average age of Ohio's congregate participant is 73 years of age with a statewide average of 23% of all congregate clients found to be over 80 years of age, an average of 35% considered to be "frail" by site managers and an average of 30% for whom the congregate meal is the only meal of the day. These survey numbers do not describe a nutritionally "well" congregate population. Therefore, nutrition services appear to differ from other CBLTC services in that the "community-based" congregate nutrition program continues, with transportation, to serve a significant number of frail and less "well" elderly in community settings outside of their homes.

In support of this concept the committee also heard that in Massachusetts where transportation is available, case managers supervising CBLTC services for clients now include congregate meals as a CBLTC service option (ODA telephone survey, 1988; ODA Nutrition Study Committee, 1988). And a study of the Maryland Congregate Nutrition Program, conducted by NASUA and Savant, Inc., that suggests congregate meal site models targeted to moderately and highly impaired groups, also supports that professionals in the field of aging see a definite future role for the congregate program in serving a LTC population (NASUA & Savant, Inc., 1989).

Hazards in Producing and Delivering Meals

In their final discussions about what factors make nutrition services substantially different from other in-home or community-based programs, the ODA Nutrition Study Committee considered several unique facts about meal service. Unlike some other CBLTC services, before congregate or home-delivered meal service can take place or be delivered to the client, a meal must be produced or procured by the nutrition provider. This makes the service more complicated than many other aging services, just as it would complicate transportation service if all transportation providers were required to first build their vehicles.

Manufacturing or procuring the meal requires a very specific and high level of expertise in staffing and adds complicating federal, state and local laws and rules to the implementation of this service. Those laws and rules don't apply just to the production of the meals, but also to the delivery of meals which requires certain technologies not required by any other CBLTC service.

And finally, the meal and its delivery is highly regulated, because in this country history shows that we regulate by law what can be life threatening or a major public health disaster. According to the Food and Drug Administration (FDA), "the" priority public health safety issue related to food is the microbiological contamination of food. Meal service from production through delivery and even after, has the great potential to become a public health hazard, especially for those already frail and debilitated. And the more often that this service is repeated, the greater the chances that human error, contamination and the elements of time and temperature will combine to create a major foodborne illness incident. It is unlikely that most other CBLTC services carry this potential level of harm for the client, if not performed properly (Weisheit, 1989; ODA Nutrition Study Committee, 1988).

Conclusion

The Committee discussed numerous aspects of nutrition services and long-term care. In summary nutrition services appear most significantly different from "other" in-home CBLTC services because of this service's ability to immediately and directly impact on the client's life. Less dramatically but no less significantly, nutrition services also have direct and immediate impact on stabilizing and even improving the frail and ill client's health or medical condition, as well as an immediate and direct impact on the frail and ill client's recuperation versus rehospitalization.

Nutrition services are different from any other CBLTC service for which a client's need and priority for the service can be determined by an assessment of functional status performed by a variety of trained staff. For a client at nutritional risk, their comprehensive nutritional needs can only be determined by a specialized individual nutrition assessment performed by qualified and trained health personnel determined by state law found in Ohio Revised Code (Ohio Revised Code, 1987).

Nutrition services are different than other CBLTC services in that through the congregate program a very frail and debilitated population can continue to receive both preventive and supportive care in a congregate community setting. And finally, meal service carries with it potentially lethal hazards for the client if not performed properly, making it quite different from other CBLTC services.

Committee Recommendations

1. ODA should seek further research and studies that may quantify relationships between functional status, nutritional status and the types of nutrition services clients need.

2. ODA should insure the development and implementation of CBLTC assessment procedures and eligibility criteria for CBLTC services that allow the provision of nutrition services even if that is the only CBLTC service needed.

3. ODA should study further the role of the congregate nutrition program in serving the frail elderly eligible for CBLTC services.

4. ODA should give priority to and provide comprehensive and on-going training for all AAA and nutrition provider staff in sanitation and safety in the production and delivery of food, emphasizing the unique safety issues for home-delivered meal service.

B. How does targeting affect the provision of nutrition services?

As stated earlier in this report, the issue of improved targeting of services to those clients most in need of services is important and better methods and innovations for targeting need to be developed. Most would agree this is based on the fact that service demands now and in the future exceed funding sources. The aging network is now looking more closely at targeting and hoping it will be one centerpiece in solving the puzzle of meeting increased demand for service with fewer public dollars. The hope is if we target better we should be able to serve more of those in the greatest need more cost effectively. That is not to say more inexpensively.

The 1987 amendments to the OAA emphasizes targeting services to individuals with greatest social and economic need, with particular emphasis on low-income minority individuals. These are not new goals for OAA funded nutrition programs. The nutrition network has lived with the goal of targeting services to low-income minorities since its beginning stages of development in the early 1970s. And with greater emphasis from Congress for the aging network to be more accountable for targeting, including improved evaluation of results, there could be a renewed effort by nutrition programs to develop better strategies for targeting. However, there is a contradiction to achieving these goals when the OAA and federal regulations prohibits "means testing" for Title III services.

In 1987 in Ohio, 51% of all nutrition clients served were reported as low-income clients. This represents 19% of all 60+ low-income elderly for the state based on 1980 census information. Thirteen percent (13%) of all nutrition clients served in Ohio in 1987 were reported as minorities. This represents 19% of all 60+ minority elderly for the state based on 1980 census information. Major differences in the percentage of minority clients served exist between the congregate and home-delivered clients (see Chapter 3 of this report).

Congregate Client Targeting for Greatest Social and Economic Need:

Because, when interpreted in the strictest sense, the OAA has prohibited nutrition programs from performing means testing of their prospective clients, targeting and reporting clients by income has been a hit or miss proposition. As a result, the main strategy for targeting used in the congregate nutrition program, has been locating congregate meal sites in low-income neighborhoods, within walking distance to heavily populated minority elderly areas. However, this method for targeting service to these groups can become inflexible.

Once a congregate site becomes established, politically it can be very difficult to move. As these neighborhoods have changed over the 16 years of program operations, a decrease in elderly residents in the neighborhood has not guaranteed a change in site location. This has left some sites operating with dwindling numbers of participants and serving even smaller numbers of low-income and minority clients. Some programs that have studied their "targeting by meal sites", have found that those elderly that have been long time participants are now on the home-delivered program and younger elderly are not attending the congregate program. In some cases this is because the neighborhoods where sites are still located are now populated with young families with children, not with younger elders.

As other programs have looked at relocating sites, they have found pockets of isolated and low-income elderly, but out in more sparsely populated sections of counties. Developing a site in one of these areas does not make it accessible to all of these areas and program transportation with vehicle, fuel and personnel costs becomes a barrier.

Home-delivered Client Targeting for Greatest Social and Economic Need:

Unlike the congregate program, no one targeting strategy for low-income or minority clients has ever clearly emerged for the home-delivered meals program. This may account for the large difference in percent of minorities served in the home-delivered program versus the congregate program when compared to the total 60+ minority population in Ohio. In addition, more accurate income information may be available for home-delivered clients than for congregate clients. Some nutrition programs do perform means testing for home-delivered meals funding sources other than Title III. If the client eventually becomes a Title III client, the income information is still available. But no uniform system to incorporate income or minority information into eligibility assessment/prioritization for Title III services has been adopted in Ohio.

Future Targeting Strategies for Greatest Social and Economic Need:

Aging network professionals, including nutrition program directors, who understand that future public funding will remain insufficient to meet service demands, agree that services need to be targeted to those eligible clients least able to afford service. The most obvious and controversial route to ensure that this happens is through client sharing of service costs. As previously stated in this report, "increased client sharing in the cost of meals is considered a viable cost containment strategy. And greater effort should be directed toward enforcing the client donation policy". Many nutrition program directors with major funding from Title III, would answer that while they cannot "force" clients to donate, they have pushed the very limits of coercing clients to donate. Many are now asking the question "If Congress won't budge on the means test issue, are there ways to legally untie the OAA "knot" of no means testing?"

The ODA Nutrition Study Committee found out that many types of targeting criteria, including income information, can and are being used to target services to Title III nutrition clients. Across the nation and in at least one PSA in Ohio, there are nutrition programs asking income information of Title III clients, although it is not verified income and no one is denied services based on their response. However, the inclusion of income and minority information in a point system for ranking clients for waiting list priority, can help when making the hard decisions of which client to serve next.

In the state of Washington, standardized, although fairly general, targeting criteria is applied to even congregate clients. This is accomplished often through a short assessment conducted over the telephone before a client is referred to a site location. Washington's broad targeting criteria for congregate clients include inability to prepare meals due to physical problems or due to lack of knowledge and training (ODA, 1989).

At the recently held annual NANASP conference in Baltimore, Maryland, two consultants from NASUA and Savant, Inc. presented the results of their statewide evaluation of the congregate nutrition program for the Maryland State Unit on Aging. The results of this statewide evaluation are interesting. These consultants suggest an assessment of all congregate sites to identify types of clients attending each site, then recommend design models where each model and the services included in that model, is designed around a mix of three distinct client types or target groups. The proposed target groups are: little or no impairment and low-income or near poor with social need; moderate impairment and low to moderate income with social need; and high impairment and low-income with social need (NASUA & Savant, Inc., 1989).

In January, 1988 ODA published more detailed nutrition client eligibility criteria policies and procedures for statewide use by AAAs. However, from the recent nutrition provider survey it appears that for home-delivered meal service, a variety of eligibility criteria and tools are still being used around the state. ODA is unaware of any Ohio nutrition program using individual criteria, other than age and OAA specifications for congregate client eligibility. The nutrition provider survey showed that while 83% of providers do use written assessment tools/policies/procedures/criteria to assess home-delivered clients, only 42% of nutrition providers indicate they use written home-delivered meal client prioritization process/tool/criteria. With the ODA nutrition office in the process now of writing nutrition program standards, the timing appears right to further develop standardized eligibility/prioritization criteria for at least home-delivered meals clients (ODA Nutrition Study Committee, 1988).

Targeting by "Well", "Ill", "Frail", "Disabled", "Short-term", "Long-term", or "Nutritional/Health Risk": The Dilemma

Because food is necessary for life, food is needed by all elderly, well and ill, rich and poor. Deciding which elderly to serve food to first, in a service system with limited funds, is like a hospital emergency room trying to write policy that defines which patients to serve and which patients to turn away. There are no ready and certainly no easy answers.

The ODA Nutrition Study Committee discussed the OAA term "frail" in the context of targeting nutrition program services. In the OAA "frail" is defined as "physical or mental disability...that restricts the ability of the individual to perform daily tasks or which threatens the capacity of an individual to live independently" (OAA, 1987). Unfortunately this definition does not provide the basis to discriminate between frail elderly suffering from acute and chronic illness, and the disability that may result, or between the frail "old" old and frail "young" old and this definition does not define who of all the frail is at greatest risk for malnutrition or inadequate nutrition and may have a higher priority for nutrition intervention and nutrition services.

Currently even for the limited services of meals and basic nutrition education, the Title III Nutrition Program runs the gamut of clients served. "Young" old and "old" old and well and disabled and health-impaired cients come to congregate nutrition sites. "Young" old and "old" old, short, intermediate and long-term disabled and health-impaired clients, as well as clients too emotionally disturbed to attend congregate sites, are on home-delivered programs. Some nutrition program directors have recognized that serving short-term clients allows them to serve more clients with the funding they have and there is satisfaction in playing a key role in a client's rehabilitation to independent living. Many of these short-term clients, discharged from hospitals quicker and sicker, are in critical and immediate need for nourishment with nowhere else to turn. As a result they are placed on a home-delivered meal program quickly and can become the clients with greater priority for services. Other program directors seem to be serving long-term clients, helping this group to maintain independence by staying out of institutions longer. These directors know their home-delivered meals help to stabilize the health of long-term clients. Yet the nutrition programs serving long-term clients haven't done this based on policy and program design any more than have the nutrition programs serving greater numbers of short-term clients.

One common thread that does appear to run among many nutrition program operations is that they have not been instructed to prioritize, have not been given training or tools or criteria from states or AAAs, and have only been required to provide client statistics that address, age, homebound status and any obvious handicapping condition(s). They also have been given no sophisticated computer programs to track or analyze client information in any other way. One other common thread may be that many feel the only moral way they can decide who and who not to give "the staff of life" to, is by "first come first serve" only.

Science has helped us identify certain groups of individuals that are considered to be at greater risk for inadequate nutrition and resulting health complications. It stands to reason that some of these same groups become chronically and functionally impaired and perhaps sooner than others not at greater nutritional risk. But the study committee and ODA staff are unaware of any research that definitively tells us this or tells us which of the groups that are at higher risk for inadequate nutrition have greater priority to receive food.

The only other public health food and nutrition education program that has actually prioritized recipients into five categories for eligibility, based on income and nutritional and medical risk criteria, is the Health and Human Services funded Women, Infants, and Children's (WIC) Program. The WIC program, which is administered in Ohio through the Ohio Department of Health, allows pregnant women, newborn infants and toddlers up to nursery school age children, to be determined eligible to receive supplemental food and nutrition education based on their priority ranking in one of five categories. When public funds are adequate WIC clinic personnel enroll clients in all five categories. When public funds are inadequate or cut back, individuals enrolled, but prioritized in lower categories, are removed from the program and no longer receive services.

Many administrators and nutrition professionals have experienced the WIC priority sytem as extremely difficult to manage and difficult for clients, although just like the elderly most clients are grateful for even a small amount of service. How this type of priority system would work with the short-term or long-term disabled and health-impaired elderly, often dependent on the nutrition program for their only food, is questionable.

Conclusion

Better targeting using minority status and income information will take some effort on the part of the aging network and yet compared to developing a reasonable system for targeting nutrition and food services by client "need", this appears straightforward and almost simple. As in the example of the emergency room, there are no easy answers and there is no one defined, agreed upon and rational way to ration food to all senior citizens in need.

Perhaps part of the answer lies in how much and what kind of nutrition and food service? That and subpopulations at greater nutritional risk are discussed in the next section.

Committee Recommendations:

1. ODA needs to evaluate the feasibility of statewide standardization of eligibility criteria and assessment tools for both congregate and home-delivered meal service.

2. If found feasible, ODA needs to develop, implement and evaluate appropriate statewide standardized eligibility criteria and assessment tools for congregate and home-delivered meal service.

3. ODA needs to include in statewide standardized eligibility criteria, factors of income and minority status.

4. ODA should review and revise, where appropriate, the funding formulas for home-delivered meals, to facilitate targeting.

C. What subpopulations of elders can benefit from nutrition services?

From a medical and health viewpoint all elders can benefit from nutrition services. As previously discussed, nutrition services are both a preventative and supportive service. National studies have found that unlike younger groups inadequate nutrition among those over 60 is not confined to one economic, racial, or demographic stratum (USDA, 1965; DHEW, 1972; Ten State Nutrition Survey, 1972). The 1971-72 HANES survey, a national health and nutrition study, indicated that over half of those surveyed over age 60 were consuming diets inadequate in one or more nutrients. Goodwin, et al. (1983) indicates that specific nutritional deficiencies may exist in as much as 50 percent of the independent living elderly in this country. Also 85% of all older persons have one or more chronic potentially debilitating diseases and could benefit from nutrition intervention and services (Committee on Education and Labor, 1982; Roe, 1983; Posner & Krachenfeld, 1987). Posner & Krachenfeld also indicate that up to 50% of all older persons have clinically identifiable nutritional problems requiring professional intervention. Inadequate nutrition is wide spread and is based on a complex interplay of factors related to acute and chronic disease as well as income, ability to procure. prepare and store food, educational level, social isolation (especially living alone) and limitations in functional capacity (often associated with either acute or chronic disease) (Posner, 1979).

Subpopulations at Greater Nutritional Risk

Given unlimited funding, all elders could benefit from some level of nutrition intervention and services. These national studies and experts indicate that a substantial portion of those over 60 are at nutritional risk. However, OAA and federal regulations target specific groups for Title III nutrition program services and meals. In addition, the nutrition literature documents that some subpopulations are at potentially greater nutrition and poor health risk. These groups include the following:

a. **low income** (Jordan, et al., 1954; Lyons, et al., 1956; USDA, 1965; LeBovit, 1965; HANES, 1971-72; Guthrie, et al., 1972; Rawson, 1978; Hunter, et al., 1979; Posner, 1979; Natow, et al., 1980; Norton, et al., 1984; Posner and Krachenfeld, 1987; Epstein, et al., 1988);

b. **minority** (HANES, 1971-72; Ohio Department of Health, 1987; U.S. DDHS, 1988);

c. **isolated** (Weinberg, 1972; Exton-Smith, 1973; Posner, 1979; Natow, et al., 1980; Roe, 1983; Chernoff, et al., 1985);

d. **acutely ill** (Posner, 1979; Natow, et al., 1980; Wolinsky, 1983; Watkins, 1983; Watson, 1986; Posner and Krachenfeld, 1987; Reilly, et al., 1988; Smith, 1989; Hedberg, et al., 1989);

e. **chronically ill** (Ten State Nutrition Survey, 1972; Posner, 1979; Natow, 1980; Fenandez, 1981; Committee on Education and Labor, 1982; Roe, 1983; Goodwin, et al., 1983; U.S. DHHS, 1988);

f. **chronic handicapping conditions** that affect food preparation, eating and nutrient utilization (Exton-Smith, 1973; Natow, et al., 1980; Fernandez, 1981; Roe, 1983).

The following paragraphs will briefly address each group.

Low Income

Low income elders have been targeted under OAA and federal regulations since the program's inception. Posner (1979) indicates that poverty may be the most important determinant of inadequate nutrition among elders. Given the choice between housing, heat, and food, many low income individuals chose to cut down on food. Poverty limits the ability to obtain an adequate diet. Inadequate nutrition contributes to and exacerbates both acute and chronic illness. Poverty also limits access to adequate medical care and subsequent follow up and treatment. Studies also document increased rates of chronic illness, and disability among low income elders.

Minority

The new amendments to the OAA emphasize targeting minorities especially low income minorities. Being both a low income and minority elder increases the risk of nutritional inadequacy and poor health status. HANES, one of the most extensive nutritional and health study of minorities documented that 36% of Black elders consumed less than 1,000 calores a day and had diets low in iron, protein, calcium, vitamin A and C all essential nutrients for maintaining basic health and functioning. The U.S. Surgeon General Report indicates that mortality and morbidity rates for disease differ by gender and race and that there is increased incidence of specific chronic diseases, which require nutritional treatment and management, among minorities. The Ohio Governor's Task Force on Black and Minority Health found that there was excess mortality among Ohio's minority groups, especially Blacks and Hispanics. Poor nutrition was cited as one of three major risk factors contributing to this increased morbidity and mortality rates (Ohio Department of Health, 1987).

Isolated

Social isolation and psychological and emotional stress may influence an individual's appetite and desire to prepare and consume food. Loss of appetite or unwillingness to prepare meals may be a symptom of loneliness, depression, loss of self-esteem or dignity and social isolation. The living situation, especially living alone, in either an isolated rural or urban setting influences food intake, nutritional status and therefore overall health. These individuals are at an increased risk of inadequate nutrition and poor health. In addition, physical isolation may present a barrier to adequate nutrition by limiting ability to procure food. If an elder lives a long distance from a store or has no transportation, and the store has no delivery service, an elder may only purchase foods that are easily carried and can be stored without refrigeration or any elder may be limited in how often he/she can obtain transportation for shopping for food.

Acutely Ill

Acute illness (digestive disorders, foodborne illness, viral or bacterial infections, respiratory infections, injuries, parasitic diseases, etc.) affect the nutritional, health, and functional status of the elderly. Acute illness may alter digestive absorption, utilization, metabolism, and increase or decrease the need for specific nutrients, thereby affecting nutritional status which affects health status. Poorer nutritional and health status delay recovery from illness and increases medical costs. A recent study in two general acute care hospitals (Hedburg, et al., 1989) indicated that approximately one third of total patients identified at nutritional risk were both over age 65 and had already stayed in the hospital greater than twice the average hospital stay of 7.2 Days. Prolonged length of stay due to inadequate nutritional status/support greatly increases the overall cost of medical care (Wolinsky, 1983; Smith, 1989; Hedberg, et al., 1989; Reilly, et al., 1988). As a result of implementation of the prospective payment system for medicare, hospitalized patients are being discharged "quicker and sicker" with an increased demand for home-delivered meals. These meals are essential to aid recovery. Providing for increased nutritional needs both in and out of the hospital is essential for recovery from illness (Watkin, 1983; Watson, 1986; Posner and Krachenfeld, 1987). Acute illness also affects the functional status of elderly by impairing the ability to feed oneself and obtain and prepare food. Acute illness may confine a person to bed or severely limit activity within the home. The duration of disability associated with acute illness is greater among the elderly than any other age group. Without adequate nutritional support due to altered nutritional needs, anorexia, health problems or inability to feed oneself or obtain food, recovery from illness is delayed or prevented and may result in a debilitating spiral into poorer health or chronic illness.

Chronically Ill

Eighty five percent of elders have one or more chronic diseases that have been documented to benefit from therapeutic nutrition intervention in treatment and management (Committee on Education and Labor, 1982; Roe, 1983). Diseases in which nutrition plays a major role in treatment and management includes diabetes, hypertension, cardiovascular disease, osteoporosis, obesity, anemia and renal disease. Treatment of other chronic diseases such as chronic obstructive pulmonary disease, cancer, or gastrointestinal disease includes a nutrition component. In addition since chronic diseases of several organ systems may co-exist at the same time, therapeutic diets with different restrictions may be superimposed on each other. Because several food restrictions/modifications may be required, therapeutic diets may be complicated, require special preparation and careful dietary counseling. Currently very few nutrition providers in Ohio offer either therapeutic meals or therapeutic dietary counseling to either congregate or homebound elders. Because therapeutic diets may be complicated, and limited dietary counseling is available, many elders may not understand the dietary treatment and management of their chronic disease, and may consume an inadequate or inappropriate diet which may result in nutritional deficiencies and even poorer health.

Chronic Handicapping Conditions

Acute illness, chronic illness, or chronic handicapping conditions - all may affect a person's ability to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Disabled elders, especially more severely disabled, may have reduced food intake unless they can obtain assistance in procuring and preparing food and in eating. Low food intake may result from paralysis (as in a stroke), dementia (organic brain disease such as Alzheimer's disease), crippling disorders (arthritis), incoordination (Parkinson's disease), mobility problems (arthritis, fractures, amputations, stroke), low vision or blindness (due to diabetic retinopathy, cataracts, etc.), mental illness (depression, substance abuse), mental retardation (central nervous system damage, inadequate training and skills), hearing impairment (multiple causes). Some chronic handicapping conditions (low vision or blindness, hearing impaired, mental retardation or mental illness) may be a lifetime disorder and may have interfered with acquiring skills and training necessary to procure and prepare food and eat a nutritious diet. Some chronic handicapping conditions may alter nutrient needs and metabolism (Alzheimer's disease, mental retardation, conditions requiring multiple drugs for management) and therefore still result in inadequate nutrition from a "normal" diet. Some chronic handicapping conditions are a result of more recent illness or injury. However, all may interfere with the ability to obtain a nutritious diet and maintain health.

Comprehensive Nutrition Services? Yes. Necessary for Every Client? No.

The previous discussion documents the need for nutrition intervention and services for subpopulations of elders at nutritional and health risk. No studies exist to prioritize which subpopulation is at greater risk and would benefit more from nutrition services. All subpopulations need food or meals to live; however, the kind or level of nutrition services needed by each group may be different.

Another way of looking at how subpopulations can benefit from nutrition services is by length or kind of service needed; short, intermediate or long duration. Little information is available in the literature describing the reasons for elders beginning, continuing on, or leaving the home-delivered meals program (Frongillo, et al., 1987). These reasons can include either or both health and nutritional factors as well as social support factors. Different health and nutritional needs as well as social needs would dictate different levels and kinds of nutrition services and would need to be individualized for each elder. Frongillo, et al. (1987) found three different groups of elders with distinctively different program duration needs based on reasons for enrollment. These include short duration clients, (elders with acute or terminal illnesses) intermediate duration clients (elders with conditions likely to improve with medical care) and long duration clients (elders with chronic debilitating illness and disabilities permanently impairing their mobility). Nutritional needs and levels of service for each group are distinctively different. Elders with terminal illness may need only meal service that emphasizes quality of life; elders recovering from an acute illness (short duration) or respiratory diseases (intermediate duration) may need aggressive nutrition intervention treatment and meal service to improve recovery chances and prevent rehospitalization. Elders with chronic mobility problems (long duration) may need nutrition intervention that helps maintain them in their homes and prevent nursing home admission.

Conclusion

From a medical and health viewpoint, all elders need food to live and benefit from some level of nutrition services. The nutrition literature documents that multiple subpoplations are at greater nutritional and therefore health risk. The literature also indicates that little has been studied or written about different levels and kinds of nutrition service needed by each at risk subpopulation. Nutrition services must be tailored to meet individual needs and level of service for all at risk individuals.

Committee Recommendations

1. ODA needs to continue to pursue additional funding in order to serve as many of the at-risk subpopulations as possible.

2. ODA needs to provide appropriate training for all AAA and ODA-funded nutrition providers to seek additional funding in order to serve as many of the at-risk subpopulations as possible.

3. ODA needs to continue to seek studies that clarify how to prioritize at-risk clients for nutrition services in order to maximize client benefits and enhance program effectiveness.

4. ODA should consider attempting to evaluate different nutrition services needed by clients beginning with CBLTC home-delivered meals clients. ODA should collect and analyze data on existing CBLTC clients concerning medical/health conditions, duration of participation in CBLTC services, reasons for termination from services and if a therapeutic diet order (including type) or supplement was prescribed by the client's physician.

D. Which kind of expertise should AAAs have on staff?

The Need for Nutrition Experts

The U.S. Surgeon General, the National Association of Nutrition and Aging Services Programs (NANASP) and the Gerontological Dietetic Practice Group of the American Dietetic Association (ADA) all recommend the use of credentialed nutritionists/registered dietitians at state, area and nutrition provider agencies and at other appropriate agencies in the aging network. Fortunately, the Ohio Department of Aging has a history of hiring graduate-level educated registered dietitians to administer nutrition services statewide. As a result, the benefits of having registered dietitians at the AAA and provider level have long been recognized and supported in Ohio. ODA has a long standing policy requiring the expertise of nutrition and dietetic trained personnel on either the AAA or the local nutrition provider level (Chapman & Sorenson, 1988; NANASP, 1984; GNDPG, 1979).

As the Nutrition Study Committee looked at the current responsibilities AAAs must perform to competently plan for, oversee and administer nutrition services programs, it became apparent that these responsibilities are complex if for no other reason than the complexity inherent in the services themselves. Currently AAAs need specific expertise in basic nutrition and aging, food service production, nutrition education, nutrition training and consulting and public health administration. With Ohio's move into CBLTC with greater in-home services and the diversion of clients from early or inappropriate nursing home placement, additional expertise in clinical dietetics and therapeutic treatment modalities will be needed on all levels of nutrition program administration.

Understanding food production and catering, meal delivery, unit-cost contracting, education, counseling and training needs all within the context of nutritional needs during normal aging and chronic disease, will be necessary for any aging services program to adapt and expand nutrition services to the more complex and sophisticated needs of a community-based long-term care population. The future of aging services points nutrition program staffing needs, on both the AAA and local provider level, clearly in the direction of registered dietitians and nutrition trained paraprofessionals (ODA Nutrition Study Committee, 1988).

While not all registered dietitians come to the aging network with years of experience in aging programs, basic college coursework, completed by ADA registered dietitians, includes basic nutrition and aging, food service production, clinical dietetics emphasizing chronic disease and therapeutic diets as well as some development in consulting skills. If standardized and well coordinated, on-the-job training from the state agency can quickly orient and train a AAA Nutrition Coordinator, (who is a dietitian), in the areas of monitoring, consulting, training and public administration. On the other hand, AAA personnel that have public administration and/or social service background alone cannot gain the full and necessary nutrition and food service expertise discussed earlier, through orientation, on-the-job training or even years of exposure to the aging network nutrition program.

Ohio's Licensure Law

Because the move into CBLTC prompted ODA and the Nutrition Study Committee to look at the need for nutrition screening, nutrition assessment, therapeutic diet counseling and the addition of nutrition consultation in a multidisciplinary approach to CBLTC, Ohio's dietetic licensure law was also discussed by the study committee. The dietitian licensure law in Ohio is written to define the scope of practice for dietitians consulting in the area of dietetics. The definition of the "practice of dietetics" from Section 4759.01(A) of the Ohio Revised Code is as follows:

"The practice of dietetics means any of the following:

(1) Nutritional assessment to determine nutritional needs and to recommend appropriate nutritional intake, including enteral and parenteral nutrition;

(2) Nutritional counseling or education as components of preventive, curative and restorative health care;

(3) Development, administration, evaluation and consultation regarding nutritional care standards."

Anyone practicing dietetics as defined by the law must be licensed or exempted as specified in Section 4759.10 of the Ohio Revised Code. One example of such an exemption that has implications for CBLTC is a licensed registered nurse. However, nurses can vary widely in the amount and type of nutrition training they have received in their academic and clinical education and training. As a result many nurses feel unqualified and unprepared in their ability to complete a comprehensive nutrition assessment and to counsel clients and caregivers in the area of clinical dietetics (Ohio Revised Code, 1987; ODA Nutrition Study Committee, 1988).

Staffing Alternatives

Although Ohio's dietitian licensure law appears to complicate the inclusion of important and lacking nutritional care and services into Ohio's CBLTC assessment and care process, the Nutrition Study Committee discussed several workable staffing and process alternatives developed by the ODA Nutrition Administrator. Because it is unlikely funds will ever be sufficient to place a dietitian in every home setting, alternative staffing ideas were developed to infuse nutrition expertise into the CBLTC system while containing costs.

These staffing ideas may also address the problem some rural PSAs have in recruiting dietitians to work as full-time AAA Nutrition Coordinators (ODA Nutrition Study Committee, 1988).

Alternative staffing ideas include hiring licensed dietitians (with clinical dietetics experience) as full-time AAA nutrition program staff and consultant licensed dietitians where a AAA has been unable to recruit a licensed dietitian for a full-time position. These dietitians, trained by the ODA Nutrition Office, would be responsible for the nutrition care portion of CBLTC services, including hiring and supervising dietetic technicians where appropriate, and training existing CBLTC nurses and social work staff to perform routine nutrition screening. Development of follow-up comprehensive nutrition assessments and therapeutic diet consultation and counseling could be handled in several ways, using a system that includes the dietetic technician, the trained nurse and the licensed dietitian. This system would meet Ohio law and still control for cost. These AAA dietitians would also be responsible for the quality assurance activities for CBLTC nutrition services and conduct nutrition training of homemaker and home-health aide staff responsible for in-home meal preparation, especially therapeutic meal preparation.

These staffing concepts serve to build on current AAA and CBLTC staffing across the state and do not cause Ohio to replace its current AAA nutrition staff network. The actual number of AAAs with licensed dietitians in full-time AAA Nutrition Coordinator positions is 8 of the 12 positions statewide. Three of the other four AAAs (all rural) have or plan to contract for consultant licensed dietitian services.

Staff Training

Committee members and ODA staff also discussed how the lack of state-level training funds has prevented routine statewide AAA and nutrition provider staff trainings. Although over the past several years, with AAA and provider director turnover, numerous requests for training have come to the ODA Nutrition Office. The ODA Nutrition Administrator has identified the lack of training for Ohio's nutrition administrative personnel, as a key problem contributing to an overall lack of service innovations and few alternative (other than public) funding sources in Ohio's elderly nutrition program. Only 14-16% of Ohio's nutrition providers surveyed during this study indicated fundraising as a source of revenue. Even less (5%) received corporate donations. Two Ohio nutrition programs, Life Care Alliance in Columbus, Ohio and the Western Reserve Area Agency on Aging in Cleveland, Ohio are participating in the Meals on Wheels America program which provides training and support, including $5,000 in match money, for community fundraising for home-delivered meals. The sharing of their training and fundraising experiences could help the rest of Ohio's nutrition providers.

Conclusion

From their discussion the committee indicated a unanimous understanding about the need for dietitians and other nutrition-trained staff at the AAA and local provider level. As a result they made several recommendations for adequate nutrition staffing and restated their earlier recommendation for ODA to pursue the addition of adequate nutritional expertise and comprehensive nutritional care to CBLTC programs.

Committee Recommendations

1. ODA should revise their AAA nutrition policies and staffing standards to require at least one full-time Nutrition Coordinator position filled by a licensed dietitian (preferably actively registered with the American Dietetic Association for the broadest nutrition, food service and clinical dietetic academic background) at every AAA.

2. The ODA AAA nutrition policies and staffing standards should allow for the contracting of consultant dietitians (in addition to the full-time Nutrition Coordinator position) when all attempts by the AAA have failed to attract a licensed dietitian for the full-time Nutrition Coordinator position.

3. ODA should develop standardized AAA Nutrition Coordinator and consultant dietitian job responsibilities to be used statewide. These job responsibilities should reflect the broader role of the Nutrition Coordinator and consultant dietitian in the CBLTC system.

4. The ODA Nutrition Program standards should require that all AAAs that do not directly administer the nutrition program in their PSA, insure that their nutrition providers have also contracted for or hired adequate dietitian services.

5. The ODA Nutrition Program standards should require that all AAAs that do have direct administrative responsibilities for the nutrition program in their PSA, review and determine with ODA, the adequacy of a single full-time Coordinator position and hire additional full or part-time nutrition staff (dietitians, dietetic technicians) to adequately administer a PSA-wide program.

6. ODA should pursue funding for and develop one or two pilot programs that formally incorporate nutrition screening, assessment and as comprehensive nutritional care intervention as possible into the PASSPORT program and any future CBLTC model programs. The pilot programs should incorporate the alternative nutrition staffing ideas developed by the ODA Nutrition Office.

7. The ODA Nutrition Office should develop ongoing statewide training programs for nutrition staff including:

    - a standard orientation program for new AAA Nutrition Coordinators;

    - routine annual or semi-annual statewide trainings for both AAA and provider nutrition staff, emphasizing nutrition program standards and topics identified through this study provider survey.

8. All trainings should be conducted to emphasize networking and the sharing of practical service methods and procedures among the PSAs.

CHAPTER FIVE

RECOMMENDATIONS SUMMARY

The numerous recommendations formulated by the study committee centered on five areas: Assessment/Eligibility; Staffing; Training; Funding and Research/Evaluation. In reviewing the Committee's recommendations the ODA Nutrition Office has developed a suggested workplan for accomplishing many of the recommendations. The preliminary workplan can be found in the Appendix. A summary of the Committee recommendations follows.

I. ASSESSMENT/ELIGIBILITY

A. ODA needs to evaluate the feasibility of statewide standardization of eligibility criteria and assessment tools for both congregate and home delivered meal service.

  1. If found feasible, ODA needs to develop, implement and evaluate appropriate statewide standardized eligibility criteria and assessment tools for congregate and home delivered meal service.

  2. ODA needs to include in statewide standardized eligibility criteria, factors of income and minority status.

B. ODA should review and revise, where appropriate, the funding formulas for home-delivered meals, to facilitate targeting.

C. ODA should insure the development and implementation of CBLTC assessment procedures and eligibility criteria for CBLTC services that allow the provision of nutrition services even if that is the only CBLTC service needed.

II. STAFFING

A. ODA should develop standardized AAA Nutrition Coordinator and consultant dietitian job responsibilities to be used statewide. These job responsibilities should reflect the broader role of the Nutrition Coordinator and the consultant dietitian in the CBLTC system.

  1. ODA should revise their AAA nutrition policies and staffing standards to require at least one full-time Nutrition Coordinator position filled by a licensed dietitian (preferably actively registered with the American Dietetic Association for the broadest nutrition, food service and clinical dietetic academic background) at every AAA.

2. The ODA AAA nutrition policies and staffing standards should allow for the contracting of consultant dietitians (in addition to the full-time Nutrition Coordinator position) when all attempts by the AAA have failed to attract a licensed dietitian for the full-time Nutrition Coordinator position.

3. The ODA Nutrition Program standards should require that all AAAs that do not directly administer the nutrition program in their PSA, insure that their nutrition providers have also contracted for or hired adequate dietitian services.

4. The ODA Nutrition Program standards should require that all AAAs that do have direct administrative responsibilities for the nutrition program in their PSA review and determine with ODA, the adequacy of a single full-time Coordinator position and hire additional full or part-time nutrition staff (dietitians, dietetic technicians) to adequately administer a PSA-wide program.

III. TRAINING

A. The ODA Nutrition Office should develop ongoing statewide training programs for nutrition staff including:

- a standard orientation program for new AAA Nutrition Coordinators;
- routine annual or semi-annual statewide trainings for both AAA and provider nutrition staff, emphasizing nutrition program standards and topics identified through this study's provider survey.

1. ODA needs to provide appropriate training for all AAA and ODA-funded nutrition providers for developing strategies for increasing nutrition service options.

2. ODA should give priority to and provide comprehensive and ongoing training for all AAA and nutrition provider staff in sanitation and safety in the production and delivery of food, emphasizing the unique safety issues for home-delivered meal service.

3. All training should be conducted to emphasize networking and the sharing of practical service methods and procedures among the PSAs.

B. ODA needs to provide appropriate training for all AAA and ODA-funded nutrition providers to seek additional funding in order to serve as many of the at-risk subpopulations as possible.

C. ODA needs to facilitate nutrition provider networking with other innovative service providers to develop strategies for increasing nutrition service options.

IV. FUNDING

A. ODA should pursue funding for and develop one or two pilot programs that formally incorporate nutrition screening, assessment and as comprehensive nutritional care intervention as possible into the PASSPORT program and any future CBLTC model programs. The pilot programs should incorporate the alternative nutrition staffing ideas developed by the ODA Nutrition Office.

B. ODA should continue to seek additional funding to expand nutrition services and provide training for AAA and ODA-funded nutrition providers on methods of fund raising to expand nutrition services.

1. ODA needs to continue to pursue additional funding in order to serve as many of the at-risk subpopulations as possible.

V. RESEARCH/EVALUATION

A. ODA should consider attempting to evaluate different nutrition services needed by clients beginning with CBLTC home-delivered meals clients. ODA should collect and analyze data on existing CBLTC clients concerning medical/health conditions, duration of participation in CBLTC services, reasons for termination from services and if a therapeutic diet order (including type) or supplement was prescribed by the client's physician.

B. ODA should study further the role of the congregate nutrition program in serving the frail elderly eligible for CBLTC services.

C. ODA should seek further research and studies that may quantify relationships between functional status, nutrition status and the types of nutrition services clients need.

1. ODA needs to continue to seek studies that clarify how to prioritize at-risk clients for nutrition services in order to maximize client benefits and enhance program effectiveness.

APPENDIX

OHIO NUTRITION SERVICES SURVEY

January, 1989

- -

1. Should you have any questions about this survey, please call **614/466-5623.**

2. Please return the completed survey along with other requested information (see Questions 9, 41 & 42) in the pre-addressed envelope by February 21, 1989.

   Should the pre-addressed envelope become separated from the survey, the completed survey should be sent to:

   Nutrition Survey
   Ohio Department of Aging
   Division of Health & Community Services
   50 West Broad Street/9th Floor
   Columbus, Ohio 43266-0501

3. If you wish to add written comments to any question, please use the back of the survey page or staple additional sheets to the survey.

THANK YOU

OHIO NUTRITION SERVICES SURVEY

1. Please print the offical name of your agency and your principle mailing address.

____
Agency Name

____
Street City Zip

2. Please list the name and phone number of one person in your agency we can contact if necessary about the answers in this survey.

______________________ ______________________
Name Phone

3. Circle which of these three categories best describes your agency.

   A. Government
   B. Non-Profit Agency
   C. Proprietary (For-Profit Agency)

4. Circle the letter of the following categories which best describes your agency.

   A. Nutrition Service Provider (agency provider, nutrition services only)
   B. Senior Center
   C. Community Action Organization
   D. ODE Certified Home Health Agency
   E. City or County Government Agency
   F. Hospital
   G. Nursing Home
   H. Other Nutrition/Social Service Non-Profit Agency
   I. Other, Please specify ______________________

5. What nutrition services does your agency directly provide? (Circle all letters that apply.)

   A. congregate meals
   B. home delivered meals
   C. nutrition education
   D. shopping assistance
   E. client find
   F. mass outreach

6. How many years has your agency been providing nutrition services?

______________ years

7. As best you can determine, how many individuals 60 years of age and older reside in your advertised nutrition service delivery area? (This means the actual number of seniors in the delivery area, not just those currently receiving nutrition services from your agency.)

______________ 60 years and older individuals

8. How was the number reported in Question 7 determined? (Circle all that apply.)

A. Census data
B. Agency survey
C. Estimated
D. Other, please specify ______________________________________
E. Do Not Know

9. Please attach a map of the county or counties which contain your advertised nutrition service delivery area. Please shade in the portion of the county(ies) which contain your service delivery area.

10. As best you can determine, what percentage of client referrals to your congregate and/or home delivered meal programs come from the following sources?

CONGREGATE

A. Client himself or herself ______%
B. Family, friend or church ______%
C. Social/Health Service Agency ______%
D. Hospital ______%
E. Home Delivered Meal Program ______%
F. Other ______%

HOME DELIVERED

A. Client himself or herself ______%
B. Family, friend or church ______%
C. Social/Health Service Agency ______%
D. Hospital ______%
E. Congregate Meal Program ______%
F. Other ______%

11. For each of the services circled in Question 5, indicate the amount of funds your agency receives from the various sources for any 12 month period that generally represents your current income.

Source of Agency Income	CONGREGATE	HOME DELIVERED	NUTRITION EDUCATION	SHOPPING ASSISTANCE	CLIENT FIND	MASS OUTREACH
Title III (Older Americans Act) (do not include local match)	______	______	______	______	____	______
Title XX (Social Services Block Grant) (include local match)	______	______	______	______	____	______
Medicaid	______	______	______	______	____	______
United Way (also called Community Chest or United Appeal)	______	______	______	______	____	______
Assistance for Independent Living (AIL)	______	______	______	______	____	______
Client Contributions	______	______	______	______	____	______
USDA	______	______	______	______	____	______
Local Tax Levy	______	______	______	______	____	______
Fund Raising (not to include regular, ongoing client contributions)	______	______	______	______	____	______
Corporate Donations	______	______	______	______	____	______
Other, please specify	______	______	______	______	____	______
______________________________ ______________________________ ______________________________ ______________________________						
TOTAL	______	______	______	______	____	______

12. If you indicated funds through fund raising in Question 11, please describe what the fund raising activity is/was.

____

____

____

____

13. If you received resources (other than cash) through corporate donations, please describe in what form the corporate donations are/were provided (e.g., actual food.)

____

____

____

____

14. How many nutrition sites do you currently operate?

____

15. How many congregate and home delivered meals did your agency serve last year?

__________ Congregate

__________ Home Delivered

16. Circle the days your agency provides congregate and/or home delivered meals.

Congregate	Mon.	Tues.	Weds.	Thurs.	Fri.	Sat.	Sun.	Do Not Provide
Home Delivered	Mon.	Tues.	Weds.	Thurs.	Fri.	Sat.	Sun.	Do Not Provide

17. What percentage of your congregate and home delivered meal clients receive weekend meals? (If agency serves weekend meals for both Saturday and Sunday, count client only once not twice.) Enter zero, if none.

__________% Congregate ________% Home Delivered

18. Circle the letter(s) of the option(s) your agency currently offers.

A. Food Pantry Program (grocery distribution to the very needy)
B. Commodity Distribution Program (e.g., free cheese given to needy elderly)
C. Congregate Supper Program
D. Congregate Breakfast Program
E. Meals for "Homeless" (Soup kitchen, etc.)
F. Nutrition Supplement Program (Ensure, Sustacal, Mix-a-Meal, NutriTreat, etc.
G. Modified or Special Diets
H. Luncheon Clubs (small groups of frail elders meet weekly in home or elderly hi-rise)
I. Supper Option for Home Delivered Meals
J. Ethnic Meals (this does not include "special" meals served in your regular program, but rather a program that serves exclusively ethnic meals)
K. Contracts with Diners/Restaurants to Provide Meals (this is separate from any routine catering contracts)
L. Regular Visits by Nursing Home residents to Nutrition Sites
M. Information and Referral
N. Food Stamps accepted in lieu of cash donations
O. Holiday Meals

19. Of the options which your agency does not currently provide, please circle the letters of the top five options for which your agency receives a significant number of requests and/or considers priorities in meeting the nutrition needs of the elderly.

- A. Food Pantry Program (grocery distribution to the very needy)
- B. Commodity Distribution Program (e.g., free cheese given to needy elderly)
- C. Congregate Supper Program
- D. Congregate Breakfast Program
- E. Meals for "Homeless" (Soup kitchen, etc.)
- F. Nutrition Supplement Program (Ensure, Sustacal, Mix-a-Meal, NutriTreat, etc.
- G. Modified or Special Diets
- H. Luncheon Clubs (small groups of frail elders meet weekly in home or elderly hi-rise)
- I. Supper Option for Home Delivered Meals
- J. Ethnic Meals (this does not include "special" meals served in your regular program, but rather a program that serves exclusively ethnic meals)
- K. Contracts with Diners/Restaurants to Provide Meals (this is separate from any routine catering contracts)
- L. Regular Visits by Nursing Home residents to Nutrition Sites
- M. Information and Referral
- N. Food Stamps accepted in lieu of cash donations
- O. Holiday Meals
- P. Weekend Meals

20-23. Please complete Questions 20-23 to indicate answers about your waiting lists for each of the nutrition services your agency provides.

	CONGREGATE	HOME DELIVERED	NUTRITION EDUCATION	SHOPPING ASSISTANCE
20. Is there a waiting list maintained for this service? Circle your answer.	YES NO	YES NO	YES NO	YES NO
21. If YES, then how many clients are currently on this waiting list?	____	____	____	____
22. If YES, then how many weeks must the typical client wait on the waiting list?	____	____	____	____
23. If YES for congregate or home delivered meals, then how are clients selected from the waiting list to receive services? Circle your answer.	first come first serve based on individual assessment other, please describe below	first come first serve based on individual assessment other, please describe below		

23. CONTINUED - Use this space only if you need to explain how you select clients from a waiting list.

24. If you provided a number in response to Question 22 for congregate and home delivered meals, is this number fairly consistent throughout the year or does it vary a great deal? (Circle the appropriate letter.)

CONGREGATE	HOME DELIVERED
A. Consistent	A. Consistent
B. Varies	B. Varies

25. If you provided a number in response to Question 22, how long has your agency had to have a waiting list for congregate and/or home delivered meals? (Circle the appropriate letter.)

CONGREGATE	HOME DELIVERED
A. Had to begin one within the last twelve months	A. Had to begin one within the last twelve months
B. Have only had one for the past one to two years	B. Have only had one for the past one to two years
C. Have had one for more than two years	C. Have had one for more than two years

26. Please indicate the number of full-time equivalent (FTE) paid staff and volunteers your agency has directly working in the nutrition program. (FTE equals 40 hours per week, e.g., two half-time employees (20 hours/week) equal one FTE.)

A. Number of FTE staff ______________
B. Number of Volunteers ______________

27. Of the number of full-time equivalent (FTE) paid staff indicated in Question 26, indicate the type of staff.

A. Number of FTE licensed registered dietitians __________
B. Number of FTE licensed social workers __________
C. Number of FTE nurses __________
D. Number of FTE nutrition site managers __________
E. Number of FTE food service workers __________
F. Number of other FTE workers __________
Specify other type of worker(s) ____________________

28. What is the average contribution from congregate and home delivered meal clients?

A. Congregate clients __________
B. Home delivered clients __________

29. Describe the methods utilized to encourage clients to provide contributions. (Do not list procedures, such as how client contributions are collected, counted and/or banked.) Include a discussion of any special campaign your agency has conducted to increase client contributions.

____

____

____

____

____

30. Please indicate the primary means of transportation used by clients to travel to your congregate meal sites. (Please indicate only one main or primary means of transportation for each client in calculating total percentages for each option. Estimate percentages where exact data is not available.)

A. Clients' own automobile __________ %
B. Private Taxi __________ %
C. Neighbors __________ %
D. Church Group __________ %
E. Senior Citizen Bus/Van __________ %
F. Friends and Relatives __________ %
G. Volunteers __________ %
H. Public Transportation __________ %
I. Walking __________ %
J. Other __________ %

31. Does your agency operate any nutrition sites located in adult day care facilities? (If no, skip to Question 35.)

A. Yes
B. No

32. If you answered yes in Question 31, indicate how many sites are located in adult day care facilities.

______________ Number of sites

33. If you answered yes in Question 31, please indicate if any Title IIIC (Older Americans Act) funds are used to fund the following in the adult day care facilities.

A. Adult day care operations are funded with Title III C funds.
B. Adult day care staff are funded with Title III C funds.
C. Adult day care meals are funded with Title III C funds.
D. No Title III C funds are used in the adult day care facilities.

34. How are client contributions handled at adult day care facilities where Title III C funds are used? For example, are client contributions donated to the nutrition program? Are adult day care clients encouraged to make contributions for the meals?

____

____

____

QUESTIONS 35-45 PERTAIN TO HOME DELIVERED MEALS AND CLIENTS ONLY.

35. As best you can determine, indicate the total number of unduplicated home delivered clients by age your agency served in 1987 and 1988. (If nutrition program client data is not available by the following age groupings, please indicate in what age categories your client records are kept.)

	1987	1988
A. Below 60 years of age	______	______
B. 60 - 64	______	______
C. 65 - 74	______	______
D. 75 - 84	______	______
E. 85+	______	______
TOTAL	______	______

Records of clients by age are kept in the following categories ___________

____

36. As best you can determine, indicate how many of the total unduplicated number of home delivered clients served in 1987 and 1988, were/are female. (Indicate the actual number or percentage of clients.)

	1987	1988
A. Female	______	______

37. As best you can determine, indicate the length of time the total number of unduplicated home delivered clients served in 1987 and 1988 have been receiving the service. (Indicate the actual number or percentage of clients.)

	1987	1988
A. Less than 3 months	______	______
B. 3 to 6 months	______	______
C. 6 to 12 months	______	______
D. 1 or more years	______	______

38. Are the numbers/percentages you provided in Question 37 actual or estimated?

A. Actual __________
B. Estimated __________

39. As best you can determine, what percentage of your program's current home delivered meals clients previously received congregate meals through your program?

____________ %

40. Indicate the assessment process your agency uses to determine who receives home delivered meals. (Circle the appropriate letters.)

A. formal in-home assessment administered face-to-face with potential clients

B. formal assessment administered over the telephone

C. emergency telephone enrollment with follow-up formal in-home assessment at a later date

D. Other, please specify ____

41. Does your agency use written assessment tools/policies/procedures/criteria to assess potential home delivered meal clients?

A. Yes
B. No

If you answered **yes** to this question, please provide a copy of the written assessment documents when returning this survey.

42. Does your agency use written tools/policies/procedures/criteria for prioritizing who receives home delivered meals?

A. Yes
B. No

If you answered **yes** to this question, please provide a copy of the written prioritization documents when returning this survey.

43. Who from your agency actually performs the assessment of home delivered clients? (Circle all that apply.)

A. Registered dietitian
B. Registered Nurse
C. Licensed Social Worker
D. Site Manager/Coordinator
E. Outreach Worker
F. Other health/social service worker, please specify ____

44. Does your program allow spouses under 60 years of age of home delivered meal clients to receive meals?

A. Yes
B. No

45. If you answered yes to Question 44, please estimate what percentage the spouses under 60 years of age represent of your nutrition program's total clients.

__________%

Optional Questions

46. Do you think the Nutrition Survey questions solicit an accurate picture of the nutrition programs/services your agency provides?

YES NO

If you answered "NO" to Question 46, please attach extra paper to the survey and explain how the Survey could have been improved.

47. What do you think are the three main issues (other than not enough funding) your agency faces in providing nutrition services to the elderly, particularly in regard to home delivered meals?

____

____

____

48. What nutrition program areas/topics, if any, would you (your staff) like to receive training?

____

____

____

Please return the completed survey along with: 1) copy of your agency's written assessment/prioritization/tools/policies/procedures/criteria used in assessing/determining who receives home delivered meals and 2) maps of your advertised service delivery area in the pre-addressed envelope or address your own envelope to:

Nutrition Survey
Health and Community Services Division
Ohio Department of Aging
50 West Broad Street
9th Floor
Columbus, Ohio 43266-0501

THANK YOU FOR COMPLETING THIS SURVEY

COMMUNITY-BASED LONG TERM CARE

NUTRITION SCREENING FORM*

To be utilized as a part of the initial data collection on a client. A client with a score of 15 points or more needs an in-depth nutrition assessment by a licensed dietitian.**

RECEIVED
JAN [illegible]
OHIO DEPARTMENT OF AGING

Date ________________
Client's name ________________________________
Client's I.D. number ______________________________
M __ F __ Birthdate __________________ Age _________

Parameter		Scoring possible	actual
Weight Status			
Current Weight ________ Height __________ (measured/estimated/self-reported)			
If weight is less than 90 pounds		10 points	______
Recent weight loss? ______			
10 pounds or more in last 6 weeks		10 points	______
10 pounds or more in last 6 months		5 points	______
Does client appear to be: normal weight ______			
overweight ________		3 points	______
underweight ________		5 points	______
Factors Affecting Food Intake			
Client's appetite is: Good ______			
Fair ______		2 points	______
Poor ______		5 points	______
If poor appetite of longer than 3 months duration		5 points	______
Presence of any of the following sufficient to interfere with food consumption:			
frequent nausea ______		5 points	______
frequent vomiting ______		5 points	______
chewing problems ______		5 points	______
swallowing problems ____		5 points	______
Food Intake			
Does the client regularly (at least once daily) consume foods from these groups?			
fruits and fruit juice _________	if no,	2 points	______
vegetables, cooked and raw ______	if no,	2 points	______
milk and cheese ______________	if no,	4 points	______
meat, fish and poultry _________	if no,	4 points	______
breads,cereals,pasta __________	if no,	2 points	______
Alcoholic beverages ______	if 2 or more daily,	5 points	______

Nutrition Screening Form, page 2

Parameter	Scoring possible	actual
Diet Restrictions		
Does the client have any diet restrictions (physician ordered or self-prescribed) ________		
if one restriction	5 points	_____
if two or more restrictions	10 points	_____
Medical Problems		
Has the client been hospitalized or had serious illness in the last 3 months _______ if yes,	5 points	_____
Does the client take several different medications (physician prescribed or over-the-counter) each day?		
2-3 different medications daily ________	2 points	_____
4-5 different medications daily ________	5 points	_____
6 or more different medications daily _____	10 points	_____
Does the client have frequent diarrhea ____ if yes,	5 points	_____
Does the client's skin indicate: bruising ___ if yes,	5 points	_____
decubiti ___ if yes,	10 points	_____
Does the client show signs of confusion _____		
if moderate	5 points	_____
if severe	10 points	_____

Comments/Additions:

Total Score ________

A total score of 15 or more indicates the need for an in-depth nutrition assessment by a licensed dietitian.** It is likely that the client whose score is 15 or more also needs a complete health assessment by a registered nurse.

If the results of the initial screening do not show the need for further assessment, periodic screening needs to be implemented - e.g. a client who scores between 8-14 points-- screen again in 3 months, a client who scores less than 8 points-- screen again in 12 months.

* Screening Form designed to be used by a person who is not a licensed dietitian, but who has been trained by a licensed dietitian to administer this form.

** A registered nurse can do nutrition assessment as a part of a total health assessment, if a licensed dietitian is available to provide the training and to monitor the nutrition component of the plan of care.

NOTE: Additional information will be needed to determine if the client is in need of home-delivered meals, congregate meals, homemaker-home health aid or other assistance.

In addition to the nutrition screening information, in order to determine the client's need for home-delivered meals, congregate meals, homemaker-home health aid or other services, the following types of information will have to be evaluated in some manner:

1. Living Arrangements:
   Does the client live alone, with spouse, with children - what ages, or have other living arrangements?

2. Food Preparation:
   Can the client prepare own meals or snacks?
   Can the spouse/children/other prepare meals?
   Does the client have someone who can prepare weekend meals?
   Does the client have someone who can do grocery shopping or take client to the grocery?

3. Feeding:
   Does the client eat independently?
   Does the client need assistance or need to be fed?

4. Does the client have handicaps that interfere with eating,cooking, or shopping?
   Blind or limited sight?
   Deaf or hearing impaired?
   Use of cane,crutches,walker,wheelchair, etc.?
   Other?

5. Income:
   Food stamps, SSI, Medicaid, Other

6. Medical diagnoses and names of physician(s)

NUTRITION HISTORY AND ASSESSMENT FORM
MINIMAL EVALUATION

Name ____________ Hospital Identification No.: ____________
Street Address ____________
City, State, Zip ____________
Telephone Home ____________ Work ____________
Age ____________ Sex ____________ Marital Status ____________
Occupation ____________ Scheduled Work Hours ____________
Current Diagnosis ____________
____
Evaluated By ____________ Date ____________

A. OBJECTIVE MEASUREMENTS

Criteria

1. Anthropometric Measurements
   a. Height (cm)* ____________ lbs
   b. Weight (kg)* ____________ Actual
   ____________ Usual
   ____________ Ideal

Recent (within 6 months) Involuntary Weight Loss ____ Yes ____ No

% of Weight Loss =

$$\frac{\text{Usual Weight} - \text{Current Weight}}{\text{Usual Weight}} \times 100 = \_\_\_\_\_ \text{ \% of Weight Loss}$$

2. Laboratory Data
   a. Serum albumin*.................................____________ gm/100 ml
   b. Hematocrit*.................................____________
   c. Hemoglobin*.................................____________ gm/100 ml
   d. Complete Blood Count ....____ Normal ____ Abnormal
   e. Routine Urinalysis ....____ Normal ____ Abnormal

3. Clinical/Physical Data (check if appropriate)

Chronic Diseases

- Cancer ____
- Chronic Liver Disease ____
- Chronic Renal Disease ____
- Coronary Artery Disease ____
- Diabetes Mellitus
- Hypertension ____

Gastrointestinal Function:

- Dysgeusian ____
- Dysphasia ____
- Enteric Fistula ____
- Head/Neck Cancer, Radiation or Trauma ____
- Inflammatory Bowel Disease ____
- Mechanical Obstruction of GI Tract ____
- Persistent Diarrhea ____
- Persistent Vomiting ____

Recent Major Surgery or Illness

Type of Surgery Performed

Increased Metabolic Needs

- burns ____
- fever ____
- infection ____
- trauma ____

Increased Losses

- burns ____
- draining abscesses ____
- draining fistulas ____
- open wounds ____

Medications Taken ____________

*Refer to Reference Tables

4. Nutritional Data

a. Patient History

1. Do you now or have you ever followed a "special diet"? ___ Yes ___ No

If yes, what type of diet? ___

How long did you follow the diet? ___

For what reason did you follow the diet? ___

2. Are certain foods not eaten due to:

Allergies: ___

Intolerances: ___

Religious Beliefs: ___

Regimen (Vegetarian, Special Diet): ___

3. Do you take vitamin/mineral/diet supplements? ___ Yes ___ No

If yes, which ones: ___

4. Do you drink alcoholic beverages: ___ Yes ___ No Frequency: ___

5. Who is responsible for home food preparation ___

6. Who is responsible for food purchasing ___

7. Which meals are most often eaten away from home: ___ Breakfast ___ Lunch ___ Dinner ___ Snacks

8. Do you have trouble chewing or swallowing food ___ Yes ___ No

If yes, explain ___

9. What do you usually eat at:

BREAKFAST	LUNCH	DINNER
MID-MORNING SNACK	MID-AFTERNOON SNACK	BEFORE BED SNACK

DURING THE NIGHT ___

b. Food Intake Summary/Analysis

Food Group	Basic Four	Servings Day	CHO	PRO	FAT	KCAL
MILK						
MEAT						
FRUIT VEG						
GRAIN						
OTHERS						
TOTAL						

B. SUMMARY OF NUTRITION HISTORY AND ASSESSMENT FORM

Summary of Data: ___

Assessment: ___

Plan: ___

[illegible]

PERSPECTIVES IN PRACTICE

A nutrition screening and assessment system for use with the elderly in extended care

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One area of particular interest to health care professionals that is undergoing considerable investigation is the nutritional status of the elderly. This article describes the development, implementation, and evaluation of a procedure used to nutritionally screen and assess geriatric patients in extended care at the Veterans Administration Medical Center in Houston. As we developed the system, we considered the special needs and characteristics of geriatric individuals and incorporated them into two forms. Designs were selected to make our method comprehensive, concise, and, ideally, time-efficient. The evaluation of the system included a time utilization study. This study was conducted to evaluate the efficiency of the new system compared with the efficiency of methods used hospital-wide in the past. Results suggest that the new system for reassessing the patient's nutritional status and reevaluating the nutrition care was three times more efficient.

The commitment to geriatric nutrition as a recognized field of investigation and research in the United States has resulted from the rapidly increasing elderly population in this country: In 1982, more than one-fifth of the American population was 55 years old or older (1). Extensive demands have been placed on the health care delivery system by this group (2). Persons over 65 years old use hospitals 2.8 times more often than younger individuals, and in the last two decades a substantial increase in the number of nursing home residents has been noted (1). In 1981, the number of living veterans 65 years or older was 3.3 million. The number is expected to more than double by 1990, when two out of three veterans are expected to be more than 65 years old (1).

Though information on the nutrition assessment of the geriatric patient is available, it is incomplete. The anthropometric measurements frequently used as indicators of nutritional status are not age-adjusted, and reliable group standards for the elderly are not yet available (2). Nutrition assessment standards used for young adults are inappropriate for the geriatric population, because they do not allow for the physiological changes that occur with age (3-8).

Accurate assessment of biochemical indexes for the elderly is also difficult, since normal values have not been established for healthy persons over 75 years old (9). Obtaining baseline and periodic serial anthropometric or biochemical measurements is a useful way of assessing elderly patients' nutritional status over time. Recently, reviews of the literature have been published to present some practical clinical guidelines for assessing the elderly (2-9).

The first step in the nutrition care process is screening to determine whether any potential for nutritional risk exists. The dietary staff at the Veterans Administration (VA) Medical Center in Houston identified the need for a nutrition screening form designed specifically for the elderly that could be used for data collection and internal record keeping. A nutrition assessment form in the medical record would present the dietitian's assessment of the patient's nutritional status from the information gathered. In this article, we describe the development, implementation, and evaluation of these procedures.

Identifying needs and setting goals

The Joint Commission on Accreditation of Hospitals and federal standards for long-term care require timely and periodic assessment of patients' nutrient intake and tolerance and the effect of appetite and dietary habits on food intake (10). In the past, upon a patient's admission to the Nursing Home Care Unit of the VA Medical Center, an in-depth nutrition assessment was completed and documented in the medical record progress notes. No standard forms were used to collect the information or to make serial data available, though a follow-up assessment was completed and documented every 60 days. Past documentation was reviewed when it was in the medical record. However, owing to the bulk of documentation in the extended-care setting, medical records were thinned frequently, leaving few—if any—nutrition notes for referencing.

Previously recorded statistics (such as stature, ideal weight, age, metabolic needs, and past education) were

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thus often re-recorded during the reassessment procedure. Furthermore, nutrition assessments were based on the same parameters and standards used to measure the nutritional status of younger hospitalized adults. The nutrition indexes obtained were therefore often misleading, because those standards failed to account for the declining metabolic rate, decreasing activity level, or reduction of lean body mass of the aging individual (4,5,11). The need for a more permanent and effective nutrition care process was evident.

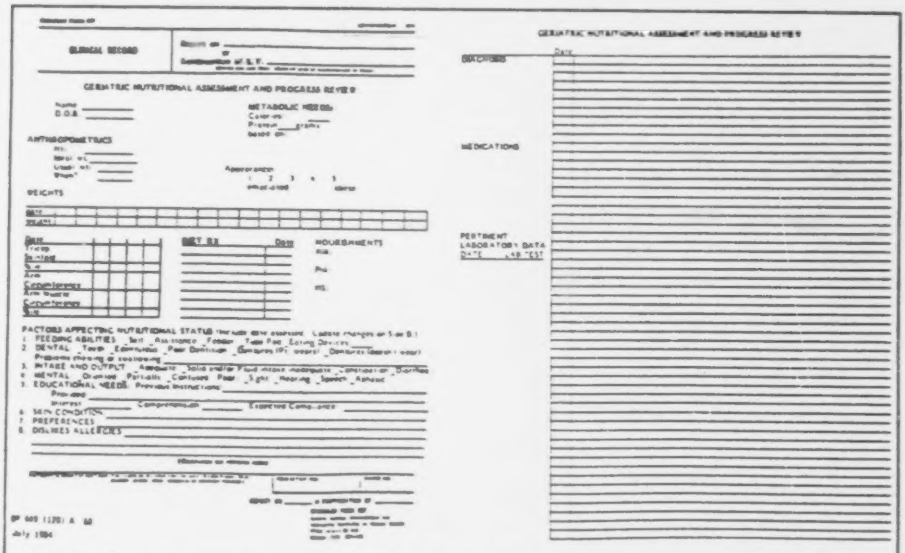
The plan for developing an improved procedure involved three goals. The first goal was to design an assessment form that could (a) be periodically updated with objective data, (b) allow reassessment of the patient without repetition, and (c) be readily located in the record for multidisciplinary referral. The second goal was to select standards specifically for estimating the energy needs and evaluating the anthropometric measurements of the elderly and incorporate them in departmental references. The third goal was to design a screening and data collection form that would (a) facilitate interviewing the elderly patient, (b) improve the effectiveness of the dietitian when the medical record was unavailable, and (c) aid in completion of post-hospital planning referral forms.

Development

Nursing homes on contract with the VA Medical Center were surveyed, and the literature was reviewed for nutrition screening methods (12-14). Forms were appraised for content, design, and appropriateness. A review of the literature was conducted to identify characteristics of the elderly that affect nutritional status (3,6,15) and standards for nutrition assessment of the elderly (4,6-8,16).

A Geriatric Nutritional Assessment and Progress Review Form (Figure 1) was developed to replace documentation in progress notes. The important parameters included were: (a) vital statistics (name, date of birth, date of admission), (b) the dietitian's assessment of the patient's appearance, (c) anthropometric data, (d) diet orders and nourishments, (e) estimation of metabolic needs, (f) age-related factors that might affect nutritional status, (g) diagnoses, (h) medications, and (i) biochemical indexes. Members of the dietary staff of the Nursing Home Care Unit had noted that changes in anthropometric and laboratory values often indicated trends suggesting repletion or depletion, which meant that serial measurements were probably more valuable than comparison of individual values to standards in long-term assessment of nutritional status. For this reason, our foremost concern in designing the form was allocating adequate space for updating of objective data during reassessment. A government medical records standard form was chosen with an overprint of the desired information. Approval of the final form was then obtained from the Hospital Medical Records Review Committee of the VA Medical Center.

Next, standards and parameters for assessing geriatric patients specifically were evaluated. The most appropriate ones were selected by the clinical dietary staff and incorporated into the departmental reference for nutrition assessment. Guidelines suggested by the National Research Council in the 1980 Recommended Dietary Allow-



CLINICAL RECORD

GERIATRIC NUTRITIONAL ASSESSMENT AND PROGRESS REVIEW

Name
D.O.B.

METABOLIC NEEDS
Calories
Protein ____ grams

ANTHROPOMETRICS

Appearance
1 2 3 4 5

WEIGHTS

DIET RX Date

NOURISHMENTS

FACTORS AFFECTING NUTRITIONAL STATUS
1. FEEDING ABILITIES
2. DENTAL
3. INTAKE AND OUTPUT
4. MENTAL
5. EDUCATIONAL NEEDS
6. SKIN CONDITION
7. PREFERENCES
8. DISLIKES ALLERGIES

GERIATRIC NUTRITIONAL ASSESSMENT AND PROGRESS REVIEW

DIAGNOSES

MEDICATIONS

PERTINENT LABORATORY DATA
DATE LAB TEST

FIG. 1. *The Geriatric Nutritional Assessment and Progress Review Form for use in the medical record (sides A and B).*

ances (11) were chosen for estimating the metabolic needs of the elderly (15) because they provide allowances for a declining basal metabolism and decreasing activity with increasing age: a 20% decrease in basal metabolic rate per decade for persons over 50 years and a 200-kcal reduction in activity per day for men and women between 51 and 75 years, a 500-kcal reduction for men over 75 years, and a 400-kcal reduction for women over 75 years (11). The staff accepted the standards of Bishop et al. (16) for assessing the body composition of patients 55 to 64 and 65 to 75 years of age. As improved standards based on larger population samples and including data from patients up to 95 years old become available, the reference may be modified.

The Geriatric Nutritional Screening and Data Collection Form (Figure 2) was designed to collect nutrition data specific to the elderly individual. The data could then be transferred to the medical record form. The screening form could be referred to when the medical record was unavailable and thus assist in the continuity of geriatric care. Several forms were drafted and tested for use in the Nursing Home Care Unit. Their characteristics were evaluated, and the form was finalized and readied for incorporation into the internal record-keeping system.

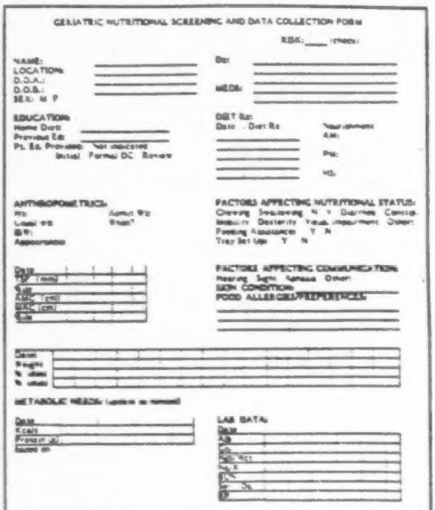
Implementation

The Geriatric Nutritional Assessment and Progress Review Form was incorporated into the medical records of 78 patients on the Nursing Home Care Unit over 4 months. The dietitians reassessed each patient, using the newly developed parameters and standards to obtain baseline values. New admissions were screened using the Geriatric Nutritional Screening and Data Collection Form and assessed using our assessment and progress review form with the new standards. The new geriatric assessment parameters were incorporated into the nutrition assessment guidelines of the hospital's dietetic service within 2 months.

Evaluation

Dietetic personnel using the newly established system in the long-term care area (dietitians and dietetic intern graduate students) and other disciplines affected by it (physicians, social workers, pharmacists, nurses, and corrective therapists) were solicited for comments on the system after implementation.

Serial evaluation of the objective data was the greatest advantage observed. Repletion or depletion was documented over time in individuals assessed periodically. Each individual's previous values served as his/her own standards and permitted more accurate interpretation of anthropometric values than possible with the other system. Nutrition goals were established for patients and evaluated regularly. Serial measurements were compared with the provision of nutrients throughout hospitalization to assess the prescribed nutrition therapy. Though an improvement over previously used anthropometric standards, the new anthropometric standards were still criticized as misleading for very old patients. Standards were still not available for patients over 75 years old, and measurements of body composition were difficult to interpret for all patients. Serial measurement and reassessment gave more credibility to the interpretation of changes in body composition.



GERIATRIC NUTRITIONAL SCREENING AND DATA COLLECTION FORM

NAME:
LOCATION:
D.O.A.:
D.O.B.:
SEX: M F

EDUCATION:

DIET Rx:

ANTHROPOMETRICS:

FACTORS AFFECTING NUTRITIONAL STATUS:

FACTORS AFFECTING COMMUNICATION:

SKIN CONDITION:

FOOD ALLERGIES/PREFERENCES:

METABOLIC NEEDS:

LAB DATA:

FIG. 2. *The Geriatric Nutritional Screening and Data Collection Form for internal record keeping.*

The Geriatric Nutritional Assessment and Progress Review Form was kept in the medical record with the list of multidisciplinary goals. The health care team in the Nursing Home Care Unit commended the accessibility of concise yet comprehensive patient nutrition information. When patients were transferred to the acute-care area of the hospital, the review form gave medical personnel easy access to historical and current nutrition information. The form was also praised as extremely useful in aiding the completion of post-hospital referral forms for community agencies and nursing home placement.

The Geriatric Screening and Data Collection Form improved the efficiency of the record-keeping system in terms of not only the quality of patient interviews but also the comprehensiveness of information collected. The dietitians believed that patients responded well to interviewing with this form, mainly because little time was spent writing down information, so that eye contact and patient interaction were permitted. Furthermore, because the questions were concise and had to do specifically with the nutrition needs of the elderly, more pertinent information could be obtained in less time.

A time utilization study suggested that the new system was more efficient. The VA Medical Center participated in a statewide time study of dietitians' activities, sponsored by Texas Woman's University, in 1985. Hospital-wide values obtained from that study for our hospital were compared with the values collected by registered dietitians on the Nursing Home Care Unit using the newly developed nutrition screening and assessment system. Average time for preliminary nutrition screening using the new screening form was 9.67±2.05 minutes; preliminary nutrition screening had previously taken 22.06±19.10 minutes. The average time for completing the Geriatric Nutritional Assessment and Progress Review Form was 25.00±5.72 minutes, whereas a comprehensive nutrition assessment previously had taken 32.63±23.58 minutes. The new reassessment procedure was found to be about three times faster than the old one: 9.59±0.42 minutes compared with 32.42±17.12 minutes per patient. The improvement in efficiency was thought to be a result of reducing repetitive activities and consolidating nutritionally significant information.

The average elderly patient uses more than twice as many medications as the average young adult. This, coupled with a reduction in drug clearance, places the elderly patient at risk of adverse drug-nutrient inter (17). Medication monitoring for potential drug-r interactions was another way patients benefited fi establishment of the new system. Medications pre are listed, and assessment of potential drug-i interactions are documented in the progress revi tion of the form. The medical staff is alerted potential risk to the patient, and appropriate modi can be made.

Clinical dietary staff members suggested apply system with modifications in other extended-car such as oncology, rehabilitation, and hospita home care. We believe that this efficient sy nutrition assessment for the elderly in long-te settings will result in improvement in the qu nutrition care.

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SUGGESTED STUDY RECOMMENDATIONS WORKPLAN

In reviewing all study recommendation categories, (Assessment/Eligibility, Staffing, Training, Funding and Research/Evaluation), the ODA Nutrition Office has developed a suggested workplan with category priorities based on two criteria:

a. implementation of categories that would be of most immediate benefit to Ohio's Area Agencies on Aging and nutrition service providers;

b. implementation of categories that were current goals of the ODA or could be implemented most quickly.

I. TRAINING

Training for AAA and select nutrition provider staff will be ongoing emphasizing AAA and provider networking and direct involvement in the training.

1989

- Nutrition Service Providers surveyed for training needs.
- AAAs surveyed for training needs through ODA Nutrition Services Questionnaire.

1990

- HD Nutrition Services Standards Training (completed in April).
- AAA Nutrition Coordinator One-day Orientation Course (scheduled to begin July; ongoing).
- ODA Sanitation Certification Course (scheduled to begin September; ongoing).

1991

- Home Delivered Nutrition Service Innovations Workshop.
- Grant/Contract Writing and Review Training.
- Fundraising Seminar.

II. STAFFING

All Committee recommendations will be reviewed for implementation with input from AAAs and Nutrition service providers.

1990

- Complete survey of AAAs for comments about suggested statewide job responsibilities list for AAA Nutrition Coordinator positions.
- Review ODA Policies and Nutrition Standards and make necessary revisions.

III. ASSESSMENT/ELIGIBILITY

1990

- Complete draft of statewide HD eligibility assessment tool and criteria for AAA and nutrition service provider review and comment. Distribute statewide for input. Finalize and field test prior to implementation.
- Review both congregate and home-delivered funding formulas for effects on targeting, revise if find necessary.

IV. FUNDING

1990

- In-home nutrition consultation has been added to the Medicaid Waiver for the PASSPORT program expansion.
- State funds for HD Nutrition Service were increased statewide 500% (January).
- OPTIONS FOR ELDERS pilot programs have designated funds for HD Nutrition Services and will serve as models for client cost sharing (April).

1991

- ODA will review effects of increased HD Nutrition Services funding to determine additional ongoing needs (ongoing).
- ODA will study the effects of increased HD Nutrition Services funding on congregate funding to determine future needs and recommendations (ongoing).

V. RESEARCH/EVALUATION

1990

- OSU Medical Dietetics students and the ODA Nutrition Office will survey a random sampling of urban and rural PASSPORT client records to assess the prevalence of nutritional problems and the types of appropriate intervention currently available.
- HD Nutrition Services Demonstration Projects are in progress with three projects funded to demonstrate service innovations in rural delivery in isolated areas and multiple meal/anytime anywhere delivery.

1991

- HD Nutrition Services Demonstration Project grants will be available again.
- ODA will consider seeking funding for research projects related to congregate nutrition services and the prioritization of nutrition services clients.

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Item 9

NUTRITION
SCREENING
INITIATIVE

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Nutrition Screening Initiative

SUMMARY

*E*vidence of the impact of nutrition on health and medical outcomes has been growing since the early 1970s. It has become increasingly clear that the nutritional status of individuals directly affects their health in clinical and community based settings. Individuals with poor nutritional status have longer and more expensive hospital stays, suffer more complications and are more likely to die. We can help improve the quality and effectiveness, and potentially lower the cost, of health care in America by incorporating routine nutrition screening and interventions into our delivery systems.

The 1988 Surgeon General's Workshop on Health Promotion and Aging called for a stepped up, coordinated national effort to promote nutrition screening and interventions in America. Through a private-public sector partnership, The Nutrition Screening Initiative is a response to that call.

AMERICAN ACADEMY
OF FAMILY PHYSICIANS

THE AMERICAN
DIETETIC ASSOCIATION

NATIONAL COUNCIL
ON THE AGING, INC.

Intitiative funded in part through a grant from Ross Laboratories

THE CHALLENGE

America has become nutrition conscious. Today more than ever, we recognize that what we eat can have a direct impact on our health. We know about cholesterol and heart disease, and there is evidence that certain dietary habits, such as low fat diets, may decrease the likelihood of developing particular types of cancer.

The same level of attention, however, has not been directed to the vital role nutrition plays in clinical and long-term care settings. Patients whose nutritional status is good tend to do better. Conversely, those whose nutritional status is poor:

- have three times the number of major complications;
- stay in the hospital two-thirds longer;
- cost several thousand dollars more per hospital stay;
- are three times more likely to die.

We are not speaking here of widespread serious acute malnutrition, the kind one equates with famine in Africa. The changes can be more subtle. We are referring to a nutritional deficit of sufficient severity to affect a patient's ability to respond to treatment, to withstand surgical procedures, to defend against infectious agents or cancer cells, to heal after surgery, or to otherwise achieve his or her potential for quality health and life.

To realize the significance of this evidence, one must bear in mind that research has shown that anywhere from 15-50 percent of the hospital and nursing home patients in the United States suffer some degree of malnutrition which is both detectable and treatable. The extent of malnutrition in the United States comes as a surprise to many well-informed people, because the issue has not been focused on or widely reported. Many people simply can't believe that poor nutrition is a significant health problem in America. But a solid and growing body of data indicates that it is.

Nutrition in this context tends to have greater relevance for certain groups of people. Those most at risk tend to be older; they also tend to suffer from particular types of primary and chronic maladies such as cancer, infections, gastrointestinal disorders, alcoholism and diabetes. These are the people whose nutritional health should be routinely measured, and then treated if necessary, to insure the best possible response to treatment for the primary health problem.

Despite the strong evidence of its preventive effects, good nutrition, to our knowledge, will not *cure* disease. But nutrition therapy will correct nutritional deficiencies, potentially prevent the development or advancement of disease, and contribute to a more rapid positive response to medical and surgical therapies.

SAVING LIVES, SAVING MONEY

We believe we can have significant impact on health care in America, including promotion of better and less expensive care and improved quality of life, by systematically incorporating nutrition screening and nutrition interventions into our medical delivery systems, particularly for the elderly. In fact, the Surgeon General's Workshop on Health Promotion and Aging recommended in 1988 that "nutrition assessment be done at admission in all institutional or community-based health services for older adults."

We should help older adults better understand the importance of nutrition in their health and health care. Educating the aged will help protect them from quackery and fads. Nutritional treatments should be provided for those individuals with poor nutritional status. The costs associated with poor nutritional status are so large that even a small avoidance of complications through improved nutrition warrants early detection and treatment.

The resources to provide screening and intervention for the elderly are already in place in many hospitals, long-term care settings, adult day care and other locations where seniors regularly congregate. Many physicians ask some of the basic questions which could comprise a preliminary nutrition screen. Most simple blood tests include parameters which also can be used to evaluate nutritional status. Many hospitals have on staff registered dietitians who can follow up screening with appropriate measures, and some nursing homes have limited access to the same services. However, the time is long overdue for formalized nutrition screening and intervention programs to become institutionalized in American health care practices wherever the system reaches those who tend to be at risk of malnutrition.

THE INITIATIVE

The Nutrition Screening Initiative is a five year, multi-faceted effort to promote greater attention to nutritional status and treatment in American health care practices. Focusing on the elderly, the Initiative will unite organizations and individuals who have been active on the issue or whose membership includes older Americans. Medical, health and aging professionals will guide the Initiative, which will include:

- promotion and expansion of existing, quality nutrition screening and intervention programs in acute and long-term care settings, as well as other locations where individuals at risk of malnutrition come in contact with health professionals;
- better networking and support for nutritionists, dietitians and others who play key roles in implementing nutrition screening and intervention programs;
- major educational outreach to physicians, nurses and other medical and allied health professionals;
- major educational outreach to providers of aging services, health care administrators, third-party payers and health care policymakers;
- educational outreach to the public, and especially to the elderly and those who care for them;
- encouragement of additional research on the efficacy and cost effectiveness of nutrition assessments and interventions to more easily facilitate the goals of the Initiative;
- advocacy of public policy initiatives in support of nutrition screening and intervention;
- communication through the mass media to help bring about greater general understanding of the role of nutrition in American health care.

Core funding for this five-year Initiative will be donated by Ross Laboratories, a division of Abbott Laboratories. Ross, maker of a variety of health and nutrition-related products, has for years advocated that greater attention be paid to the importance of nutrition. The grant from Ross is augmented by the resources and energy of key organizations and individuals who are joining in support of the Initiative.

Item 10

EXECUTIVE SUMMARY

SCREENING OLDER AMERICANS' NUTRITIONAL HEALTH:

Current Practices and Future Possibilities

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Introduction

Until recently, little attention has been paid to the nutritional status and nutrition-related needs of older individuals in this country. The changes in the age distribution of the population have crept up on us; only in the past decade have the increase in aged people and their associated malnutrition problems become apparent. Advocacy on nutrition issues for the elderly has been largely confined to efforts to expand supplemental feeding programs. These programs are essential, but they represent only one of the many nutrition-related health services needed by aging adults.

Many older persons, and a considerable number of professionals, have only a limited understanding of the role sound nutrition plays in the promotion of health and the management of acute and chronic medical conditions in the elderly. Our fundamental and applied knowledge of the relationship between nutrition and aging is still developing. In addition, there are inadequacies in nutrition research and services, a situation that is likely to continue unless there is a considerable change in the emphasis that is placed on incorporating nutritional care into this nation's health care system.

Older people experience various nutritional problems and needs that are related to the many environmental, social, economic, and physical changes of aging. These situations and their resulting effects must be studied more closely if we are to develop strategies that stress prevention of nutrition-related problems as well as successful interventions when problems become apparent.

The following is a summary of a review of existing literature concerning aging and nutrition aimed at addressing some of these issues. The review examined the prevalence of malnutrition among aging Americans. It described characteristics of aging and the negative impact of malnutrition on ability to function independently, as well as on mental and physical health. Specific problems and chronic diseases that are associated with nutrition or that affect an individual's nutritional status as they relate to the elderly were studied.

The review also considered nutrition screening techniques and interventions which have proven effective. In addition, recommendations concerning implementation of a more standard approach to nutrition screening in this country were addressed.

Finally, the review highlighted gaps in our present knowledge of nutrition and aging which inhibit progress. Needed improvements in the science base, in medical and health care practices and in public policy relating to these issues were considered as well.

Prevalence of Malnutrition Among Older Americans

Using widely accepted criteria, a substantial proportion of older Americans have dietary intakes or diseases which place them at high risk of malnutrition. The types of malnutrition include deficiencies, imbalances, and excesses in varying combinations. These result from both diet and disease.

Recent comprehensive reviews have identified obesity, hypercholesterolemia, hypertension and, among the low-income elderly, limited income for food as widespread diet-related problems with well established adverse health or social consequences (US Department of Health and Human Services 1988, Committee on Diet and Health 1989, Roe 1989, Smickilas-Wright 1990, Life Sciences Research Office 1989, US Public Health Service 1990, Life Sciences Research Office 1990). Munro et al (1987) identified calcium and vitamins D, B6 and B12 as the micronutrients most likely to be in short supply. While low iron status is found, it is rarely due to diet in the elderly, and this is also true for most folic acid deficiency.

Dietary patterns affect not only the incidence of atherosclerotic cardiovascular disease, hypertension and obesity, but also some forms of cancer, osteoporosis, diabetes mellitus, hepatobiliary disease, alcoholism and dental caries (Surgeon General's Report USDHHS 1988, Committee on Diet and Health 1989). Also, inappropriate diet contributes to the dysfunction associated with many chronic conditions which are common in aging adults. Inappropriate dietary intakes may exacerbate conditions such as diabetes mellitus, advanced renal insufficiency, hypercholesterolemia, certain forms of hypertension, constipation, gastrointestinal problems due to lactose intolerance and congestive heart failure. Increased wasting in chronic obstructive pulmonary disease, cancers of the gut and paralytic strokes may occur if their nutritional implications fail to be recognized and treated by appropriate dietary interventions.

A number of less common nutrition-related problems also have adverse impacts on older Americans. These are protein energy malnutrition and adverse drug-nutrient interactions (Anderson et al 1990). Other health problems such as fractures, osteoporosis, dental disease, physical inactivity, depression, social isolation and sensory loss also have nutritional implications and are major causes of disability. These have been highlighted as deserving particular attention in a recent report aimed at preventing disability in aging adults (Committee on Health Promotion and Disability Prevention for the Second Fifty 1990).

The result of all these problems is considerable dysfunction and disability, decreased quality of life, and in some cases increased morbidity and mortality. Table 1 provides information on the prevalence of many diet and nutrition-related diseases and conditions in persons 50 years and older from national and other survey data. They include function-related abilities involving activities of daily living, psychosocial function and capabilities, and physical health problems (Rubenstein 1990). More detailed information can be found in the full summary.

Nutrition Screening

Nutrition screening is one of the first steps that can be taken to address nutrition-related problems among older Americans. However, screening has yet to be fully incorporated into our nation's overall strategy for health maintenance and care of older individuals in this country. Nutrition screening remains an unmet health monitoring and surveillance need among aging Americans today.

Several factors are involved. Health professionals are uncertain what should be screened; this lack of consensus on basic tools for nutrition screening is a major barrier. Lack of time, limited understanding of the importance of screening, skepticism about its effectiveness, and lack of reimbursement for screening, preventive services and nutritional treatments are other barriers to implementation. Finally, health professionals and others are often unaware that reasonable, effective interventions to improve or maintain nutritional status are available.

The Benefits of Screening

Nutrition screening initiates the process of recognizing and responding to the nutrition-related problems and potential problems of older people. Screening can help identify those who are at risk for poor nutritional status, and preventive interventions can follow.

In the health care setting, screening aids in assessment, care planning and monitoring nutritional status and progress made. And from the perspective of both the patient and the health care practitioner, screening increases the likelihood that interventions will follow to deal with problems once they are discovered.

In the absence of regular screening measures in the clinical setting, the presence of malnutrition is frequently overlooked. Unfortunately, when malnutrition is neglected it tends to worsen disease and complication rates, thereby increasing health care costs. The use of nutrition screening followed up by further in-depth nutrition assessment is likely to produce more appropriate intervention and treatment plans as well as to save money.

Nutrition screening can also be helpful in assisting physicians to better collaborate with and to utilize the expertise of registered dietitians and others who deal with the nutrition problems of older adults, thereby achieving optimal efficiency and effectiveness at lower cost.

Nutrition screening and interventions are especially important for older individuals. They extend meaningful and productive lives by maximizing independence in carrying out activities of daily living and lessening days of restricted activity due to illness. In some instances, risks of disease, complications and death can also be lessened by nutritional measures.

The New Face of Nutrition Screening Today

The screening strategies of today differ from earlier efforts and offer new hope for full incorporation of nutritional screening into the health care and social service system for our nation's elderly. Screening today focuses not only on identifying those who are already experiencing nutrition-related problems, but also on those who may be *at risk* for poor nutritional status.

Screening techniques should make use of classical screening characteristics such as biochemical and anthropometric measurements. They should also probe health-promotive and illness-causing *behaviors* and other factors such as socio-demographic and economic status which can affect an individual's nutritional status. While extremely beneficial, implementation solely by public health services or mass screening makes individual follow-up difficult. Thus, nutrition screening for the elderly can be and needs to be fully integrated into personal health and social services.

Screening for Risk Factors

It is important to recognize that poor nutritional status develops in a complex yet predictable fashion. There are variables which predetermine poor nutritional status. These include type or amount of diet, which may give rise to vitamin or mineral deficiencies, undernutrition or starvation, protein calorie malnutrition, imbalances (such as those of type and amount of fat or sodium) and excesses (as of energy or alcohol). These deficiencies, excesses and imbalances may be present alone or in combination. In addition, nutritional problems secondary to disease or pathological conditions are also involved.

Associated with these variables which predict poor nutritional status are various risk factors. Risk factors are defined as characteristics which increase the likelihood that an individual will have or has problems with his nutritional status. Some of these characteristics increase risks for dietary inadequacy, excess, or imbalance and involve social, economic and lifestyle factors rather than physical health problems. Others indicate risks of malnutrition secondary to disease and/or treatment modalities rather than those caused primarily by lack of food.

The suggested nutrition screening elements and components regarding risk factors are summarized in Figure 1. Most of these measures have already been recommended for individuals over 50 years of age by the U.S. Preventive Services Task Force (1989) and other authoritative bodies.

Screening for risk factors holds the most promise for increasing the emphasis placed on prevention. Identifying individuals at risk provides opportunities for implementation of preventive measures *before* clinical manifestations of nutritional problems arise. Many causes of poor nutritional status can be addressed by anticipatory guidance and early intervention to reduce risk factors. In addition, screening for risk can help identify characteristics which should trigger further assessment for the existence of actual nutritional problems.

The Settings for Risk Factor Screening

The target population for risk factor screening should include both those who conform to traditional definitions of overt malnutrition and those at risk of having marginal nutritional status. Marginal nutritional status is a condition in which variables or risk factors for poor nutritional status are present, nutrient stores may be low, but impairment of performance, health, or survival may not yet be evident. Individuals with marginal nutritional status are at risk of malnutrition, especially when they are subjected to various physiological, social, psychological or economic stresses.

Implementation of risk factor screening of older Americans does not need to be, nor should it be, limited to health professionals. Risk factors are often evident to those who deal with or live with older individuals in the community before they are brought to the attention of health professionals. Many older persons who exhibit these characteristics are not in regular contact with health-care professionals and their nutritional health is not being monitored. In addition, for professionals in the clinical setting, changing some risk factors, such as food insecurity, is not within their means or scope of practice.

If nutritional problems are to be identified and corrected before malnutrition is manifest, some means must be developed to monitor nutritional status in community settings which include those outside the health care system. Identifying and screening for various risk factors presently offers the most promise for screening and interventions among older populations in non-medical settings. Risk factors can be identified by many individuals who come in contact with older people, such as social service professionals, volunteers, aides, and in some cases families and the elderly themselves.

Screening for risk factors outside of the medical setting provides opportunities to address the social and environmental elements that can lead to poor nutritional status. They often include unmet social needs and signal the need for improved public health and voluntary measures in the larger community and interventions involving private/public sector alliances.

Screening techniques can come into play in congregate feeding and other community activities frequented by older persons. Forms and checklists for identifying and correcting potential nutritional risks of older people receiving meals on wheels and living in residential homes have been developed and used successfully to follow up identified problems (Gerontology Nutrition Unit 1982, 1981).

The approach chosen for screening for risk factors is multi-factorial. It appropriately emphasizes not only medical but also social, economic and lifestyle indicators which are equally, if not more, important in determining risk. Such an approach implicitly recognizes the important role that individuals outside as well as inside the traditional medical care system may play in identifying individuals at risk of malnutrition. Thus it makes optimal use of the array of multi-disciplinary service and health professionals who come into contact with the elderly.

In-Depth Screening

In addition to identifying nutritional risk factors, screening can also play a key role in identifying individuals with early clinical evidence of malnutrition using clinical indicators. This is accomplished by use of in-depth screening methods. Treatment can then follow.

By targeting high risk individuals for further assessment and treatment, in-depth screening seeks to prevent remediable disorders while nutritional status is still marginal (eg. when impairment of performance, health, or survival because of nutritional status is not yet evident). And while some disease-related problems cannot be eliminated, this type of screening can aid in consultation and strategy planning to help minimize the effect on nutritional status.

In-depth screening tools consist of anthropometric indicators (e.g. weight and height, body composition); clinical indicators (e.g. oral and physical exams); biochemical indicators (e.g. serum albumin, serum cholesterol, hemoglobin, plasma glucose) and dietary indicators (e.g. dietary history, specialized assessments). Screening using in-depth indicators to determine nutritional status is suitable for medical settings, such as physicians' offices, nursing homes and acute-care hospitals. Figure 2 provides a list of additional in-depth clinical screening indicators for poor nutritional status.

Although these indicators are more difficult to obtain than the risk factors, they are more useful in assessing possible risks and in further refining the differential diagnosis. When an assessment of risk factors flags a potential problem and biochemical or dietary indicators of changes are present, nutritional problems at the cellular level may already be apparent and evident in anthropometric (physical) measurements or clinical signs.

The in-depth indicators are also useful in determining appropriate interventions once nutritional status has been determined. They further document the condition and help to shape potential intervention and monitoring strategies in the clinical setting.

Nutritional Status: A Vital Sign

Findings in the literature indicate that incorporation of strategies directed at identifying both older Americans at risk of poor nutritional status as well as those who have existing nutritional problems can be beneficial. In addition, it is useful to incorporate screening in many different settings, from the community to the formal health care system.

Nutrition screening is a vital sign of America's health and its implementation will be an indication of the willingness of our nation's professional community to address the unmet nutritional needs of older Americans.

The success of nutrition screening is also a vital sign of the political will of our nation's professionals. It will require a commitment to deal with nutritional needs in medical and community health care settings, health services administration, and public policy. Actions in all of these areas will be required to fully realize the benefits.

Consensus is Needed on Standards and Screening Strategies

Experts need to reach agreement on the likely elements in a standard nutrition screen which will be adaptable to and testable in many settings. A good deal of consensus is already apparent among experts quoted in the scientific literature. Key elements that most or all are likely to agree upon are the following:

- There are various screening techniques that can help to identify both the risk factors and indicators of malnutrition in older people.
- These in turn provide direction for effective interventions that may halt, reverse or minimize the clinical and functional consequences of malnutrition.
- There is a need for nutrition screening tools for risk factors associated with poor nutritional status, and liaison systems which enable those outside the health care system to refer older people who exhibit such indices to others for application of in-depth screening tools and further assessment if it is called for.
- Nutrition screening tools should include, at the very least, risk factors for poor diets (e.g. social, economic) as well as risk factors related to medical conditions and disease, since these characteristics are associated with many types of poor nutritional status.
- Factors which increase risk of poor nutritional status can include the early warning signs of consequences of long-standing or sudden medical or social stresses (such as surgery or loss of a loved one) which can tip the person rapidly into malnutrition.
- In-depth nutrition screening tools must include indicators of already-apparent malnutrition, including dietary intake, biochemical measures, anthropometric, and clinical signs.
- Composite indicators which employ several components of risk factors and in-depth screening are essential for definitive evidence that poor nutritional status is present. The presence of two or more risk factors plus the presence of at least one dietary, one biochemical, one anthropometric measure, and one or more measures of prior or coexisting disease (See figures 1 and 2) would be one such indicator.

The task of building consensus on a multifactorial screen for malnutrition is consistent with other current efforts to increase the nutritional health and well-being of older Americans. These other initiatives include the guidelines for clinical preventive services recently issued by the US Preventive Services Task Force (1989), the recommendations of the Surgeon General's Report on Nutrition and Health (1988), the Year 2000 Objectives for Promoting Health and Preventing Disease (US Public Health Service 1989), the guidelines of the National Cholesterol Education Program (NCEP 1990), the National High Blood Pressure Education Program (1987), the Dietary Guidelines for Americans (USDA and US DHHS 1990) and the dietary recommendations of the National Academy of Sciences for reducing chronic disease risk and consuming healthful diets (Committee on Diet and Health 1989, Food and Nutrition Board 1990).

Field Testing and Validity Testing

Once experts agree on standard risk and in-depth screens that are adaptable to and can be tested in many settings, the work of implementation begins. The steps will include determining:

- Each specific indicator to be used and its level;
- Standards for normality of the indicator in older persons;
- Practicality of indices chosen, perhaps determined by field testing;
- Validation studies of screening batteries in various settings.

The characteristics of screening tests must be described, with the assistance of statisticians and other experts in test design. The screening batteries must be assessed in different populations. It may be appropriate to start with groups thought to be at high risk.

The yields resulting from screening of new cases which can be identified and successfully treated are of special significance. Therefore emphasis must be placed on them.

Interventions

Although some causes of malnutrition are physical or mental in nature, and call for health care-related interventions, other causes are social and environmental. They often include unmet social needs and signal the need for improved public health and voluntary measures in the larger community and interventions involving private/public sector alliances (Davies 1984).

Health and social welfare professionals play a key role in a partnership with older people and their families, as well as the private, voluntary and public sectors, in implementing steps we already know can help. Professional action can also improve medical and health care practices and health care administration, as well as contribute to the development of public policy interventions to remedy system-wide problems.

Cost Effective, Well Documented, Well Demonstrated Nutrition Interventions Already Exist

Nutritional interventions vary in their effectiveness, but many are well-documented and efficacious. Some interventions involve simple remediation of a dietary deficit or excess or consumption of more or better food alone. The control or amelioration of other forms of malnutrition in older people depends upon the provision of therapeutic diets or nutritional support as adjuncts to medical therapies. The exact proportion of the conditions identified which are amenable to either or both types of therapy is presently unknown, as it is for most forms of medical intervention. Some of the best documented and tested interventions among aging and aged individuals include the following:

- *Early diagnosis and treatment* (including diet therapy) of multiple coexisting physical and mental health problems secondary to diseases is effective.
- *Assisted supplemental feeding*. Some older people have inadequate intakes because they lack the ability or strength to maintain their nutritional status on intakes consisting of usual foods in usual meal patterns. Health care providers can help by providing supplementary feeding and by arranging for feeding assistance, when needed.
- *Providing social support for isolated individuals*. Some older people are at nutritional risk because they lack social relationships which encourage them to eat. Measures such as congregate feeding programs can be helpful to them.
- *Providing meals to the bedridden or immobile* through the use of the home-delivered meal programs.
- *Special feeding routes involving enteral or parenteral nutrition* for individuals who are unable to eat by mouth. In some cases these interventions are lifesaving and often they are critical to maintaining independent functioning.
- *Assistance to aged individuals who are feeder dependent* because of mental or physical frailty, including surveillance and training of those who feed them to ensure adequate nutrition and the avoidance of secondary problems.
- *Counseling and assistance in reducing or ceasing alcohol intakes* among those with alcohol-related problems.
- *Referrals for people with dental problems* which adversely affect food intake.
- *Use of proper measures to prevent choking and aspiration* among those with swallowing disorders.
- *Physical activity and exercise regimens* appropriate to patient health status.
- *Obesity control measures to help reduce or maintain body fat levels* to minimize the health consequences of obesity, particularly among those with health problems that are worsened by its presence.
- *Drug assessment* to assure that drug doses are appropriate and adverse drug-nutrient and nutrient-drug relationships are minimized.
- *Anticipatory guidance to assure adequate hydration.*
- *Appropriate therapeutic dietary interventions* to assist in controlling *severe hypertension, type I + II diabetes, severe hyperlipidemias* (e.g. serum cholesterol over 240 mg/dL), and more moderate forms of these disorders when indicated.
- *Using and revising, as appropriate, therapeutic diets* for controlling other conditions.
- *Suggesting dietary alterations* to prevent constipation and assuring adequate intakes of dietary vitamins, minerals, protein and energy.
- *Instituting other preventive measures* for pressure sores, vaccination for influenza and pneumonia, reduction in risks of nosocomial infections, prevention of falls, prevention of incontinence, for smoking cessation and screening measures for cancers of the breast and cervix, in order to avoid these potential causes of secondary malnutrition when disease develops.

Less Well Known and Documented Interventions Are Also Good Bets for Improving Nutritional Status In Aging Americans

Several other interventions are less well-documented as to their effectiveness, but they hold much promise for improving nutritional status. They include:

- Dietary therapy (weight control, decreased sodium intake, and possibly alterations in other nutrient intakes) for treatment of mild hypertension in the elderly.
- Dietary therapy for control of moderate hyperlipidemias of 200-240 mg/dL (reduce obesity if it is present, decrease saturated fat, total fat and cholesterol, possibly increase water soluble fibers).
- Strategies to increase physical activity, assure adequate calcium and vitamin D levels and institute estrogen replacement therapy if indicated to control aging-related bone loss during middle age and onward. Preventive measures to minimize risks of falls especially in the aging and aged.
- Measures to eliminate social isolation and depression which may contribute to undernutrition in many older people.
- Comprehensive geriatric assessment, including attention to nutrition-related concerns, incorporated into routine clinical care of older people.

The Individual As His or Her Own Best Ally

Interventions to prevent malnutrition due primarily to inadequate quantity or quality of food intake do not require medical assistance once they have been identified. The actions required are those that older people can do with encouragement and support of others, including health and social welfare professionals. These include health-related behaviors such as:

- Routine medical care.
- Moderation or abstinence in alcohol intake, particularly if alcohol is associated with problem drinking.
- Awareness of what to do and how to help oneself or another to prevent choking and aspiration accidents.
- Adoption of good food handling and preparation practices to avoid foodborne illness. Food poisoning and foodborne illnesses are an unrecognized cause of sickness and even life threatening events in the aged.
- Avoidance of megadose use of vitamin and mineral supplements, and expensive, unnecessary and unproven food or nutritional nostrums for health problems.
- Appropriate use of medications, especially those with nutritional effects, and adherence to medication schedules.
- Learning to maintain fluid intake even when thirst mechanisms are impaired.
- Eating patterns to minimize the risks of dietary deficiency, obesity, constipation, and diet-related chronic degenerative disease risks or complications.
- Maintaining or initiating a physically active life style.
- Maintaining or controlling body fatness at normal levels, especially if disorders worsened by the presence of obesity are present.

Community Resources As Allies to Older People

Social welfare and health care professionals play an important role helping older people and their families find and use community resources:

- Screening for malnutrition and referring those at risk to health care professionals for further assessment.

- Linking older people who lack money to purchase an adequate diet with government and voluntary programs that provide money for food, commodity foods, congregate or home delivered meals, or broader means of economic support.
- Assisting those who are home bound to obtain nutritional, food and health services.

Future Tasks

There is an urgent need to document more fully the comparative effects of nutritional and other interventions and their costs among the elderly. Particular attention needs to be paid to their effects on function and performance rather than solely on morbidity and mortality.

Research and Public Policy

Research is essential to understand how a series of factors from lifestyles to genetics determine health status as people age, as well as how to prevent some of the declines associated with aging. It is critical that government and private-sector support continue for enlarging our fundamental knowledge base and for utilizing such knowledge to improve reimbursement practices and nutrition services. The following are the most significant needs within these arenas:

Research

Develop a more effective nutrition policy for older Americans:

- Strengthen basic knowledge of the biology of aging and nutrition, the aging process, the chronic degenerative diseases and conditions associated with aging, and how best to promote healthy aging.
- Mount clinical trials of the health consequences of promising dietary and other interventions in the older population.
- Develop dietary, biochemical, anthropometric, and clinical standards for judging nutritional adequacy in older people.
- Develop nutritional status assessment methods and tools specifically appropriate for aging individuals.

Fill gaps in clinical research:

- Develop and update standard criteria and methods for nutrition screening for the elderly.
- Develop core indicators for precise functional assessment of eating-related behaviors of older people.
- Develop screening tools for the quality of nutritional care, food services, dietetic and other health services and related health consequences in various community and health-care feeding settings.
- Improve the quality of administration and delivery of food and nutrition services in the community and long- and short-term health care facilities.
- Standardize nutrition screening protocols for health-care facilities.

- Develop broader roles for community-based feeding programs in alleviating social isolation and depression and improving prevention or early identification and treatment of health problems.

Public Policy

Expand Availability of Nutrition Services and Support:

- Study the effects of payment practices for long-term care, nutrition services, acute care and ambulatory health services for older citizens.
- Find ways to pay for nutrition services older Americans need.
- Develop a stronger community infrastructure for the support of older people and the care of the elderly as an alternative to institutionalization.
- Assess the fiscal and other consequences of the present "end-loaded" system of medical care which emphasizes efforts to avert mortality after the situation has become grave as opposed to focusing on a system that would give equal weight to efforts directed to preserving health and function and minimizing disabilities as long as possible.

Conclusion

With respect to nutrition-related medical expenditures in older Americans, like much of medical care, the system is "end-loaded," with most time and expense being spent at the very end of life, days or a few months before death. We spend far more in attempting to control the adverse health consequences of poor nutrition than we do in devising ways to make food and eating promote health and serve as a source of pleasure and solace among the aged, in preventing diet-related disorders in the first place or in treating malnutrition problems when they are less advanced. Eating, which is an activity of daily living and a source of personal and social pleasure, has often been addressed as a matter of health concern only when so deranged that it threatens to exert its own pathological effects on health. Intervention at that point turns eating into a medical event. In our efforts to avert morbidity and mortality at whatever cost we have lost a balanced focus which gives equal weight to efforts directed toward preserving health and function and toward minimizing disability.

Systematic nutrition screening and nutrition care provides an opportunity to right this balance and to begin to deal with nutritional concerns in a new manner. In place of the curative medical model, it relies on a preventive health and social services model. Health professionals, older people and their families as well as the larger community can join together as partners to focus on the promotion of quality of life as well as health and optimal functioning, prevention of nutritional risks and the amelioration of malnutrition when it is inevitable. Effort invested in screening, early identification and treatment of problems will make better use of our time and money and improve the nutritional health and well being of America's older citizens.

In spite of the uncertainties of the present, screening older Americans for malnutrition will be a useful endeavor, particularly for older people who are likely to be at high risk. It deserves serious consideration by health professionals and other authorities.

Item 11

STATE OF CONNECTICUT
DEPARTMENT ON AGING

REQUESTED APPROACHES FOR IMPROVING MEAL QUALITY AND NUTRITION EDUCATION IN THE ELDERLY NUTRITION PROGRAM

State of Connecticut Department on Aging
February 20, 1991

Three simple and direct approaches are needed for improving meal quality and nutrition education in the Elderly Nutrition Program. These should cost very little in terms of time and money to implement, a fact to be appreciated in these days of austerity. They are:

1) Develop an updated version of the "Nutrient Standard Method Guide for Menu Planning and Monitoring;"

2) Establish a food pattern for menu planning; and,

3) Provide strong Federal guidance regarding nutrition education.

I. Develop an updated version of the "Nutrient Standard Method Guide for Menu Planning and Monitoring" and make it available both as a manual tool and as a spreadsheet or simple data base for the computer.

The Nutrient Standard Method Guide for Menu Planning and Monitoring was published in 1975 by the Administration on Aging, U.S. Department of Health, Education, and Welfare. It is seriously outdated, especially in light of newer findings in nutritional science.

Most nutritionists who do menu planning for Connecticut's elderly nutrition projects are still using the old Guide. They enjoy its ease of use and efficiency.

Unfortunately, there are several substances in food which are required for healthful living that are not assured by the Guide, sodium and magnesium, for example. Sodium is needed to check for excesses. Magnesium is a chief indicator nutrient. High magnesium foods (legumes, whole grains, dark leafy green vegetables and nuts) are rich sources of many trace nutrients and fiber. Along with protein and iron rich foods, they provide vitamin B-6, copper and zinc; and, along with high vitamin C foods, provide folacin and potassium.

Other nutrients in the old Guide, namely niacin and phosphorus, could be deleted since they are no longer indicator nutrients as long as protein, thiamine, riboflavin and calcium are included. It would thus be possible to retain an efficient as well as accurate guide, since more columns would be unnecessary.

An important enhancement to the Nutrient Standard Method Guide would be to make it available for computers in spreadsheet format or as a simple database. The user should be able to select menu items by rapidly accessing food groups and quickly scrolling down through foods in each group. If put on a computer, precision could be improved by using % RDAs rounded off to the nearest whole percent as the nutrient values. This spreadsheet or database should be put, along with the program to run it, on a single 5 1/4" or 3 1/2" floppy disk.

II. Establish a Pattern for Menu Planning and Meals Service.

In addition to using the Nutrient Standard Method Guide, a food pattern should be defined, such that, if the pattern were followed, the menu would automatically be close to being nutritionally sound. A food pattern would save nutritionists considerable planning time, since only fine tuning would then be needed to bring the menu to full nutritional adequacy.

Ideally, the pattern chosen would be similar to that required by USDA for reimbursement of Adult Day Care Center meals. Unfortunately, USDA's pattern seems to reflect the needs of the farmer more than the needs of the elderly. Something in the pattern must be included to curb excess dietary fat and sodium, as well as assure adequate magnesium, trace nutrients and fiber. Attached is a Proposed Food Pattern for Elderly Nutrition, for consideration and discussion.

III. Provide Strong Federal Guidance Regarding Nutrition Education.

The Elderly Nutrition Program provides less than one half of the meals the elderly eat during the week, most meals being prepared at home. In terms of an elder's overall diet, the nutrition education component of the program is potentially more important than the meals' component. Unfortunately, this component often receives very little attention and must be strengthened. The following the minimum strategies are sought:

(1) A required budgetary line item for nutrition education.

(2) A requirement that nutrition education be provided monthly at each congregate meal site, perhaps in combination with or alternating with other health education.

(3) Basic qualifications for those providing nutrition education defined.

In Connecticut, the Nutritionist is required to meet the following minimum qualifications:

Must have two years of recent relevant work experience preferably in geriatric nutrition, food service management or community nutrition, in addition to one of the following criteria:

(1) Registered Dietitian, or

(2) Active member status of the American Dietetic Association who meets elibibility requirements for registration, or

(3) Bachelor's Degree from an accredited four year institution with a major in foods and nutrition, institutional food management, community nutrition, dietetics or related field.

One year of the work experience requirement may be waived with possession of Registered Dietitian status, and/or Master's degree from an accredited institution in nutrition, dietetics, institutional food management or related field.

A Nutrition Assistant, under the direction of a nutritionist, may also provide nutrition education. The Nutrition Assistant must meet the following minimum qualifications:

(1) Diet Technician, Registered; or,

(2) Active member status of the American Dietetic Association who meets eligibile requirements for registration; or,

(3) Associate Degree or equivalent from an accredited program with a major in foods and nutrition, community nutrition, dietetics or related field.

In the case of therapeutic diets, services of a Registered Dietition must be utilized.

A great deal of resources are spent providing food and social services, and for the administration that provides oversight and funds management, while very little is spent for education. More effort must be taken to shore up the educational aspect of the program, which costs very little by comparison. Any effort made in this area should reap enormous benefits.

DRB.073/aa

Proposed Food Pattern for Elderly Nutrition

Food Group	Serving/Unit Size Examples	Minimum Servings 1st Meal	Servings 2nd Meal	Both
Grains	1 oz. dry; 1 slice; 1/2 cup cooked	2	2	4
Milk	1 cup lowfat milk, yogurt, cottage cheese 1 oz. hard cheese	1	1	2
High Protein	1 oz. meat, nuts, cheese 1/3 cup ckd dry beans, lentils 1/2 cup peas 1/4 cup cottage cheese 1 egg	3	2	5
Fruits & Veg.	1 med. or 4 oz. fresh 1/2 cup cooked 1 oz. dry 6 oz. juice	3-4	1-2	5
Sub Group				
High Vitamin C		1	-	1
High Vitamin A (every other day)		(1)	-	(1)
High Magnesium*		2-3	1-2	4
Fat	tsp. or equivalent**	3-5 max.	2-4 max.	7 max
Sodium	count if = 250 mg. in a serving	1-3 max.	0-2 max.	3 max

*Whole Grains, Legumes, Dark Leafy Greens, Nuts. (2 slices rye or wheat bread containing whole grain flour may substitute for 1 slice 100% whole grain bread.)

**Count each oz. fatty meat, cheese, egg, serving of most pastries; as well as, spreads, salad dressing, gravy, etc.

Item 12

GN

Gerontological Nutritionists

February 11, 1991

Address replies to:

P. O. Box 687
Madison, MS 239130

I am pleased that so many distinguished leaders in nutrition will be present on February 15, 1991 at the Senate Special Committee on Aging "Elderly Nutrition Workshop." GN is fortunate to be represented by Kathryn Bisnirjian, Legislative Chairman. I know that Kay will present many of the views expressed by the GN membership. However, I would like to reiterate some of the focal issues that we hope you will make sure are addressed.

1. Although the revised Dietary Guidelines will be extremely helpful to the adult population, there remains a crucial need for adapting guidelines for the older population that will more directly meet their needs.

2. Of the nearly 2000 GN members, many are involved with the Title IIIc programs have expressed a need for assessing the nutritional services to assure that these services are viable, target the appropriate population, and provide guidance, instruction, and counseling from individuals with expertise and training in gerontological nutrition.

3. Expansion of the Recommended Dietary Allowance to differentiate needs of the younger old and older old are past due.

4. Uniformity is needed in the assessment and provision of nutritional services through the development of standards of care.

5. A viable reimbursement system for community based nutritional assessment and counseling needs consideration.

These areas are only a small part of the many needs related to educating and serving the older population to maintain optimum nutritional health. I concur with the findings and recommendations of the Nutrition Working Group (pp. 80-83) stated in the Proceeding of the "Surgeon General's Workshop, Health Promotion and Aging" on March 20-23, 1988.

Thank you for your continued support in helping to preserve the integrity and quality of life of our older population through your interaction with government officials. I look forward to your comments on the Workshop.

Sincerely,

Linda R. Shoaf

Linda R. Shoaf, PhD RD
Chairman

cc: Kathryn Bisnirjian
Linda Netterville
Judy Dailey

A PRACTICE GROUP OF
THE AMERICAN
DIETETIC
ASSOCIATION 216 West Jackson Boulevard, Suite 800 Chicago, Illinois 60606-6995

Item 13

DATE: February 14, 1991

TO: Julie Stauss, R.D.

FROM: Janet Eigenbrod, R.D. Janet

RE: Requirement For A Registered Dietitian At Local Levels

Recent developments in our state have confirmed my conviction that Registered Dietitians at the local level could provide a stronger nutrition network.

Background: There are sixteen area agencies and sixteen nutrition programs in our state; one nutrition project for each area agency having identical boundries. Thirteen of the sixteen programs are directly delivered by the area agency.

Problem: In December the Indiana Area Agency on Aging Directors (I4A) voted to no longer allow financial support of Title III-C dollars for The Indiana Nutrition Directors Association(INDA). Rather they would establish constituent units (of which Nutrition would be one) under the umbrella of the I4A. Further discussions indicate the board for this umbrella organization would have four area agency directors and only one nutrition representative.. The premise for the action is improved networking and coordination among all aging services and the area agency.

Discussion: INDA has experienced strong leadership and development over the years resulting in statewide visibility. The area agency directors evidently view this as a threat. To mediate , INDA suggested they would come under the umbrella but requested INDA be recognized as the constituent unit for nutrition. This has been denied. INDA had previously requested representation at I4A meetings and for I4A to send representation to their meetings for better communication. This too was denied. As a result of this action much resentment and mistrust has evolved.

Comment: I fear this control by Area Agency Directors could spread to other states. This could weaken NANASP and the Nutrition Network. This could make our work for ADA even more difficult. Any help you can provide in your efforts to improve Nutrition Programs would be greatly appreciated.

Standard: A requirement for a full time registered dietitian on the staff of the Area Agency or provider level if funding is less than $300,000 for representing nutrition issues to maintain comprehensive quality, cost effective nutrition programs.
Rationale: When the requirement is "qualified" personnel as currently written in The Older Americans Act, any rationale can be used to fit the candidate. A registered dietitian demands required credentials and provide the common goal of improved nutrition for those we serve.

Item 14

GA
FOOD SERVICE, INC.
12200 32nd Ct. N. St. Petersburg, Fl 33716 (813) 573-2211

Senate Special Committee on Aging
The United States Senate
Washington, DC 20510-6400

Thank you for organizing and hosting the roundtable discussion on Elderly Nutrition policy issues on Friday, February 15th. I thoroughly enjoyed it and believe there were a great many important issues brought out.

I had an additional point I would like to make regarding the discussion of the meal pattern method of determining 1/3 RDA as presented on the NAMP handout entitled "Minimum Standards For Older Americans Act Nutrition Programs". Julie Stauss suggested I submit it to you for inclusion in the final transcript. Please feel free to edit this letter to include only the points I would like to make.

As the handout states, meal patterns have become the rule rather than a guide in many states--there are quite a number I am aware of that include them as part of state regulations pertaining to the program. If programs, under the supervision of legitimately credentialled nutrition professionals such as Registered and/or Licensed Dietitians, are to have the flexibility to explore ways to make menus more consistent with the U.S. Dietary Guidelines, as well as more cost effective, I believe they must have more flexibility than the meal pattern allows. I also believe this must be addressed at the federal level in order to give consistent guidance to all the states.

I submit a statement such as the following could be included: "Meal patterns would not take precedence if menus can be shown to contain 1/3 RDA and be consistent with the U.S. Dietary Guidelines."

Another reason why I believe federal guidance in this matter is crucial is by virtue of my position as Corporate Dietitian for a food processing company marketing preportioned, frozen meals to Elderly Nutrition Programs in over thirty states.

If some states chose to become creative with their menus by decreasing the protein serving requirement and increasing the serving(s) of starches, fruits and/or vegetables it would make our job of providing a widely accepted, cost effective and high quality meal virtually impossible. It would not be possible to come up with different serving sizes for each different state pattern.

Finally, on Friday several people alluded to the "taking away" of an ounce of meat/alternative and I submit that this should be looked at from the positive position of what could be put on in its place. Meat is traditionally the most costly part of a meal and financially it would be possible to increase the number of servings of breads/starches and/or fruits and vegetables probably by as many as two or three by eliminating one ounce of meat. By so doing, the U.S. Dietary Guidelines would more closely be followed and the clients would end up with more food which, I believe we all agreed, they can surely use!

Thank you for allowing me to add this additional input and once again, thank you for your time and effort in organizing the workshop.

Yours truly,

Linda C. LaVine, RD,LD
Corporate Dietitian

Item 15

Marilyn T. Mower, MA, RD, LD
19113 Roman Way
Gaithersburg, MD 20879

February 18, 1991

Senate Special Committee on Aging
G-31
Dirkson Senate Office Building
Washington, DC 20510

Re: Minimum Standards for Older Americans Act Nutrition Programs

This letter is written to support the Minimum Standards presented at the Roundtable Discussion on February 15, 1991. It is essential that these standards be incorporated into the Older Americans Act. Establishing minimum standards for nutrition programs at the federal level will provide guidelines to ensure high quality nutrition programs at the local level. Participants at the Roundtable testified that these nutrition programs have been effective in increasing quality of life and decreasing health care costs for the elderly.

In order to provide high quality nutrition programs in the most cost-effective way, it is essential to have professional persons with nutrition and food service expertise involved in program design, implementation and evaluation, research and development, at all levels - federal, regional, state and local. When a provider supplies a significant portion of total meals for a nutrition program, it is important that the provider have the services of a person with nutrition and food service expertise.

Registered dietitians are the professionals who are certified to have nutrition and food service expertise, and it is essential to require that persons with such qualifications be employed in nutrition programs at all levels. I have been the Registered Dietitian for the nutrition program in Montgomery County, Maryland, for 1 1/2 years, a new position created in 1989. During the past year, I have had many comments from participants and staff relating to increased professionalism and improvements in the quality of the program.

The minimum standard for meals - that each meal provide 1/3 of the RDAs, averaged over five days - is important for programs in which only one meal per person per day is provided. However, when programs provide three meals per person per day, as in senior-assisted housing, flexibility in the energy requirement for the three meals is needed. The present energy requirement is the recommendation for a 51-year-old male, whereas most of the persons receiving three meals a day in senior-assisted housing are over 75 years and female. As people age and become less active, they need fewer calories. In addition, on the average, women need fewer calories than men. For a 75-year-old female, energy need is around 1500 calories which is less than 75% of the recommendation for a 51-year-old male. However, the need for other nutrients - protein, vitamins and minerals - does not diminish with age, and these nutrients should be maintained at present levels.

Thank you for inviting me to participate in the Roundtable Discussion. The format was successful in eliciting participation from most of the persons attending, and the presentations were valuable in stimulating participation and further thought about the nutrition program. I came away inspired and invigorated.

Sincerely,

Marilyn Mower

Item 16

dietary
managers
association

DIETARY MANAGERS ASSOCIATION'S RECOMMENDATIONS TO THE OLDER AMERICANS ACT

Background: The Dietary Managers Association is a 12,300 member professional association composed of dietary managers, most of whom are employed in health care facilities across the country. Their primary responsibility is to assure that appropriate and properly prepared meals are provided to patients, residents and guests. Of the total membership 65% have passed the credentialing examination and are considered Certified Dietary Managers. The exam, consisting of 150 questions, covers ten competency areas in three major categories: patient/client nutrition, production management and personnel/administration. To maintain certification, 45 hours of continuing education are required every 3 years.

A Certified Dietary Manager (CDM) is able to hire, discipline, train and supervise foodservice personnel. A CDM can effectively operate within budget guidelines and work with Registered Dietitians to provide quality nutritional care for patients, residents and their guests. NOTE: A separate list of regular tasks performed by a CDM has been attached as reference.

Older Americans Act: Title III of the Older Americans Act provides grants to states for supportive and nutrition services to residents 60 years and older, including congregate and home-delivered meals.

The Dietary Managers Association (DMA) supports Title III of the OAA and believes Congress should consider the CRS Issue Brief, Older Americans Act: 1991 Reauthorization Issues, as reference to the necessity and value of this program. The DMA also supports, in principle, the American Dietetic Association, the National Association of Nutrition & Aging Services Programs and the National Association of Meals Programs position on the following standards:

> 1) Meals shall incorporate the U.S. Dietary Guidelines and meet a five day time-averaged intake of one-third of the daily Recommended Dietary Allowances (RDAs) as established by the the Food and Nutrition Board of the National Academy of Sciences, National Research Council. If multiple meals are served each day the combined meals must meet 2/3 RDA for two meals and 100% RDA for three meals.
>
> **Recommendation:** DMA recommends implementation of this standard. Given the current attention and validity of outcomes research, it would be difficult to defend the argument that it is a more efficient use of resources to provide nutrition in an acute care facility, nursing home or through IV therapy. Maintaining adequate nutrition through a home delivered or congregate meal makes both financial and common sense.
>
> 2) Nutrition education shall be provided on a quarterly basis to all participants in the C-1 (congregate) and C-2 (home delivered) meal programs.
>
> **Recommendation:** DMA supports this standard and is able to assist in implementing an education program as developed by a Registered Dietitian. CDMs have the expertise and training to educate participants on the value of nutritionally adequate meals in relationship to the participant's overall health and well-being.
>
> 3) State Units on Aging must develop training guidelines to assist Area Agencies on the Aging (AoA) and nutrition program providers in developing and implementing appropriate regular and ongoing training of all network nutrition program employees and volunteers.

Recommendation: DMA supports this standard. CDMs are trained and tested in the area of nutritional education. They are qualified to assist in educating volunteers and employees of AoAs.

4) State Units on Aging must develop minimum assessment criteria for the determination of participation in the Title III-C-2 program. The criteria developed must include a reevaluation period to determine the need for continued participation by clients and should take into consideration the participant's need for other services.

Recommendation: DMA supports this standard with the understanding that assessment guidelines are developed with input from both CDMs and RDs. DMA also recommends implementation of "assessment guidelines" which can be evaluated by other employees and volunteers, given they have received the proper educational training from a qualified professional.

5) The minimum assessment criteria shall also be used to identify participants at risk for the purpose of making referrals to appropriate social service agencies and to qualified nutrition personnel.

Recommendation: DMA supports this standard and recommends that those employees and volunteers who are either delivering the meals to C-2 participants or serving the meals to C-1 participants be given general training regarding signs of malnutrition, depression or other visible effects of an individual who may be in need of additional services.

6) A minimum of one-full time Registered Dietitian shall be employed by the Area Agencies on Aging (AoA) (at the central office and at the regional office) and by each state unit on aging with administrative duties for the nutrition program that include 1) nutrition program design, implementation and evaluation, with emphasis on service cost containment, service safety, and service quality and 2) research and development with emphasis on service integration with community based programs, including the development of special nutrition services for special-needs populations and on defining the long range role for the nutrition services in community based care systems.

Recommendation: DMA supports this standard in principle; however, requiring a full-time dietitian, although ideal, may not be realistic in geographically rural or economically depressed areas. CDMs are qualified and in most cases responsible for the tasks similar to those mentioned in Standard #6 (NOTE: Please refer to attachment A). Given their current level of responsibility, training and on-going educational requirements to maintain their certification status, it appears both prudent and in the best interest of the elderly participants of Title III nutrition programs to utilize CDMs. DMA agrees that RDs are an integral component in the success of this nutrition program and support utilizing RDs as consultants on a regular (monthly, quarterly) basis. From an economic perspective, based on information from a 1989 survey conducted by the Department of Labor and Statistics, hospital employed Registered Dietitians earned $26,364.00 annually or $12.67 per hour assuming a 2080 hour work year. According to a survey conducted by the Educational Testing Service on job tasks and knowledge/skills of dietary managers, hospital employed Certified Dietary Managers earned $19,000 annually or $9.13 an hour; Nursing home employed CDMs earned on average, $17,600.00 annually or $8.46 an hour.

7) Nutrition providers must conform to the U.S. Public Health Service Code and additional State or local laws regarding the safe and sanitary handling of food, equipment and supplies used in the storage, preparation, service and delivery of meals to an older person. Each state shall set maximum delivery times and temperature requirements for hot, cold and frozen meals.

> **Recommendation:** DMA supports this recommendation. CDMs are trained and educated on the storing, preparation and serving of food supplies and meals and should be specifically utilized in implementing this standard.

DMA also supports, in principle, the ADA's position on two additional standards:

> 8) In consultation with geriatric nutrition research experts, state units on aging, agencies on aging, nutrition program providers and professional organizations (i.e ADA, NAMP, NANASP, DMA), AoA should research and develop guidelines which would integrate the following services into comprehensive nutritional therapy/intervention for special-needs populations: nutrition screening, nutrition assessment, nutrition care planning, nutrition/therapeutic diet counseling, therapeutic meals, meal supplements, and meal replacement products.
>
> **Recommendation:** DMA supports this standard. CDMs should play a role in the development of these guidelines given that on a day-to-day basis it is CDMs who are responsible for ensuring that certain evaluations are implemented and executed for reporting to the consulting RD.
>
> 9) Health promotion programs shall include nutrition counseling and educational services provided by registered dietitians as a core component and adequate funding should be provided.
>
> **Recommendation:** DMA supports this standard in principle; CDMs are certainly qualified to provide educational services to participants, employees and volunteers. With direction from a Registered Dietitian, CDMs would also be able to assist in nutrition counseling. To specifically name or imply that a Registered Dietitian is the only qualified professional capable of implementing such programs will only limit the value of this standard and the overall success of this program.

Additional Comments: In evaluating the added value of each of these standards, DMA has considered not only the manpower needs required to meet these additional standards but also the financial requirement for states to meet these standards.

DMA recommends that **Certified Dietary Managers**, as defined by the credentialing requirements of the Dietary Managers Association, be specifically named in the Act as a professional with the nutritional and food management knowledge to implement these standards under the direction of a Registered Dietitian. DMA acknowledges the clinical expertise of Registered Dietitians in the nutritional development and assessment of meals; however in those instances where Registered Dietitians are unavailable on a full time basis or full-time Registered Dietitians would be financially prohibitive to the overall objectives of this Act, DMA believes that Certified Dietary Managers are qualified to educate participants, implement and administer/manage food delivery programs, assist states in meeting the minimum requirements as established by the U.S. Public Health Service Code, work with AoA in developing and implementing additional nutritional programs, and participate in health promotion programs.

To ensure that Certified Dietary Managers play an appropriate role in programs authorized under Section 336, the DMA also recommends that **"the Dietary Managers Association"** be inserted into Section 337 of the Older Americans Act following "the American Dietetic Association."

USDA CPI Reimbursement Adjustment: DMA also supports the need for a per-meal reimbursement rate adjustment based on the increase in the consumer price index (CPI). The current reimbursement rate of 56.76 cents has been in effect since 1986. If the reimbursement rate is not adjusted regularly, at some point, participation becomes limited to those in financial need; an additional welfare program was not the intent of the OAA. DMA recommends an adjustment be made every other year. This would allow the USDA to budget accordingly and give the Title III programs incentive to be efficient in their own budgeting process. Before Congress decides to eliminate such an adjustment, as was done in 1987, consideration should be given as to where these elderly will receive their necessary nutrition. Based on a survey which appeared in AHA *Hospitals*, conducted by Monitrends on hospital meal cost (6/5/90 issue), the following information is available: direct expense per 100 meals varied from a high of $460.13 to a low of $397.58, for an average per meal cost range of $4.60 to $3.97; considerably higher than the current USDA reimbursement rate.

Attachment A

A CDM performs the following tasks on a regular basis:

1. Documentation of nutrition information in medical record.
2. Interview Patient/Client for diet history.
3. Conduct routine nutritional screening.
4. Implement diet plans and physicians' diet orders.
5. Calculate nutrient intake.
6. Participate in Patient/Client Care Conferences and interact with other health care professionals.
7. Supervise preparation and serving of therapeutic diets and supplemental feedings.
8. Develop and implement quality assurance standards and procedures.
9. Instruct patients on basic diet restrictions.
10. Develop work schedules, prepare work assignments.
11. Conduct employee evaluations.
12. Interview and select employees.
13. Supervise, discipline and terminate employees.
14. Prepare, plan and conduct departmental meetings and inservices.
15. Receive, store and distribute food, supplies and equipment.
16. Maintain standard sanitation and safety practices.
17. Manage maintenance, training and use of equipment.
18. Write policies and procedures.
19. Standardize and test recipes; develop preparation procedures.
20. Write purchase specifications and orders for food, supplies and equipment.
21. Develop annual budget and operate within budget parameters
22. Recommend salary and wage adjustments for employees

○